

# CRITICAL ILLNESS CLAIM - DOCTOR'S STATEMENT

## Heart Related Conditions

Note: This form is to be completed at the Patient's expense by the Attending Physician/ Surgeon.



### Patient's Personal Details

Name		Policy Number
<input type="text"/>		<input type="text"/>
NRIC/Old IC/Passport/Birth Cert/Others	Date of Birth	Gender
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female

The claim is being filed for the following illness: (Please tick [✓] in the appropriate box)

Sections to be completed		Sections to be completed	
<input type="checkbox"/> Coronary Artery Disease Requiring Surgery/ By-Pass Surgery	A, B, K & L	<input type="checkbox"/> Percutaneous/Min Invasive Heart Valve Surgery	A, D, K & L
<input type="checkbox"/> Other Serious Coronary Artery Disease	A, B, K & L	<input type="checkbox"/> (Minimally Invasive) Surgery of Aorta	A, E, K & L
<input type="checkbox"/> Angioplasty & Other Invasive Treatments	A, B, K & L	<input type="checkbox"/> Large Asymptomatic Aortic Aneurysm/ Dissection	A, E, K & L
<input type="checkbox"/> Keyhole Coronary By-Pass Surgery	A, B, K & L	<input type="checkbox"/> (Hypertrophic) Cardiomyopathy	A, F, K & L
<input type="checkbox"/> Minimally Invasive Direct Coronary Artery Bypass Grafting (MIDCAB)	A, B, K & L	<input type="checkbox"/> Pericardiectomy (With Surgery)	A, G, K & L
<input type="checkbox"/> Enhanced External Counterpulsation Procedure	A, B, K & L	<input type="checkbox"/> Insertion of Pacemaker	A, H, K & L
<input type="checkbox"/> Transmyocardial Laser Therapy	A, B, K & L	<input type="checkbox"/> Insertion of Cardiac Defibrillator	A, H, K & L
<input type="checkbox"/> Heart Attack/ Acute Myocardial Infarction	A, C, K & L	<input type="checkbox"/> Infective Endocarditis (Early/Late)	A, I, K & L
<input type="checkbox"/> Heart Valve Replacement/ Surgery	A, D, K & L	<input type="checkbox"/> Eisenmenger's Syndrome (Early/Late)	A, J, K & L

Note: Assessment of claims and provision of benefits will be based on the Policy mentioned in this form.

### SECTION A : Medical Record of the Patient

1. Are you the patient's regular/ family doctor?  
 YES  NO  
 If Yes, over what period do your records extend?  
 Day  Month  Year

2. Date the patient first consulted you this illness / injury.  
 Day  Month  Year

3. The presenting signs and symptoms during the first consultation with you.

4. The date when the patient first noticed the presenting signs and symptoms.  
 Day  Month  Year

5. In your opinion, how long have the presenting signs and symptoms lasted prior to the first consultation with you?  
 Day  Month  Year

6. Please describe the full and exact diagnosis and treatment advice was given.

Diagnosis Date (DD/MM/YYYY)	Diagnosis	Treatment Advice

7. Date when the patient was informed of the diagnosis.  
 Day  Month  Year

8. Which of the following factors are present? For factors which are present, please provide the date of onset.

i. Hypertension  YES  NO  Day  Month  Year

ii. Diabetes Mellitus  YES  NO  Day  Month  Year

iii. Hyperlipidemia  YES  NO  Day  Month  Year

iv. Others, please specify  
  Day  Month  Year

**SECTION B** ▪ Coronary Artery Disease Requiring Surgery/ By-Pass Surgery ▪ Keyhole Coronary By-Pass Surgery  
 ▪ Other Serious Coronary Artery Disease ▪ Enhanced External Counterpulsation Procedure  
 ▪ Angioplasty & Other Invasive Treatments ▪ Min Invasive Direct Coronary Artery Bypass Grafting (MIDCAB)  
 ▪ Transmyocardial Laser Therapy

1. Was coronary arteriography performed? If "Yes", please provide the date performed, name of medical center where it was performed and enclose copies of the results.

YES  NO

2. Please indicate the degree of narrowing (%) for each involved artery and date diagnosed.

Artery	Diagnosis Date (DD/MM/YYYY)	% of Narrowing
i. Circumflex		
ii. RCA		
iii LAD		
iv. Left Main Stem		

3. Was there any ECG changes?

YES  NO

If Yes, please state the changes and provide copies of ECG report displaying the changes.

4. What is the nature of treatment? Please enclose the copy of surgery report.

Treatment	If Yes, please provide the details.	Treatment Date (DD/MM/YYYY)	Details of Treatment
i. Coronary Bypass Graft Surgery	<input type="checkbox"/> YES <input type="checkbox"/> NO		Please select (✓) the applicable approach, <input type="checkbox"/> Open Chest surgery (E.g. Thoracotomy, Sternotomy) <input type="checkbox"/> Minimally invasive techniques (E.g. thoracoscopic / key-hole surgery) <input type="checkbox"/> Others. Please specify:
ii. Balloon Angioplasty	<input type="checkbox"/> YES <input type="checkbox"/> NO		
iii. Coronary Atherectomy	<input type="checkbox"/> YES <input type="checkbox"/> NO		
iv. Laser Treatment	<input type="checkbox"/> YES <input type="checkbox"/> NO		
v. Keyhole Coronary Bypass Surgery	<input type="checkbox"/> YES <input type="checkbox"/> NO		
vi. Transmyocardial laser revascularization	<input type="checkbox"/> YES <input type="checkbox"/> NO		
vii. Enhanced external counterpulsation	<input type="checkbox"/> YES <input type="checkbox"/> NO		
ix. Other forms of treatment	<input type="checkbox"/> YES <input type="checkbox"/> NO		Please specify:

5. Is this the first time the patient has undergone any one of the above procedures?

YES  NO

If No, please provide the date of the first procedure and type of procedure.

First Procedure Date (DD/MM/YYYY)	Type of Procedure

6. Can the medical condition mentioned previously be managed via combination of medical therapy & surgery intervention (E.g. Angioplasty, By-pass surgery)?

YES  NO

If Yes, please provide the details on the effective combination(s) on the medications & surgical interventions.

**Please attach certified true copies of all relevant reports. (E.g. Echocardiogram, Electrocardiogram, Coronary Angiogram reports Blood and Laboratory test results – CKMB, Troponin T, etc.)**

**SECTION C      ▪ Heart Attack/ Acute Myocardial Infarction (To be completed by the cardiologist)**

1. Was there a history of prolonged chest pain?

YES  NO

If Yes, please provide the date and time of the first onset of chest pain.

Day  Month  Year  am/pm

2. What was the duration of chest pain?

hours

3. Were there other symptoms?

YES  NO

If Yes, please elaborate.

4. Was there an elevation of cardiac biomarkers and ECG changes (I.e. CKMB and Troponin level) before any intervention?

YES  NO

If Yes, please provide the details of tests result of cardiac biomarkers recorded.

**Please enclose all the copy of investigation reports.**

If No, kindly provide the reason of cardiac biomarkers not performed.

5. Is there any previous episode of heart attack prior to this one?

YES  NO

If Yes, please provide the details below,

Diagnosis Date (DD/MM/YYYY)	Final Diagnosis	Treatment(s)

**Please attach certified true copies of all the relevant. (E.g. Echocardiogram, Electrocardiogram, Coronary Angiogram reports Blood and Laboratory test results – CKMB, Troponin T, ECG, exercise stress test, enzyme assays, isotope imaging, coronary and LV angiography, echocardiography, etc.)**

**SECTION D      ▪ Heart Valve Replacement/ Surgery      ▪ Percutaneous Heart Valve Surgery**

1. Please provide full details of the diagnosis including the part of cardiac structure and type of defect that was involved.

2. Was there cardiac echocardiogram or any diagnostic test done to confirm the heart valve defects?

YES  NO

If Yes, please provide the details of tests result.

**Please enclose all the copy of investigation reports.**

If No, kindly provide the reason of cardiac echocardiogram or any diagnostic test not performed.

3. Please select (✓) the applicable medical reason(s) of the surgery performed,

To repair the valvular defect(s)  
 To replace the damaged heart valve(s)

Please provide the details of surgery.

Surgery Date (DD/MM/YYYY)	Type of Surgery/ Procedure	Name of Doctor & Hospital

4. What was the surgery approach?

Thoracotomy  Percutaneous  
 Key-hole surgery  Intra-arterial

**Please attach certified true copies of all relevant reports. (E.g. Echocardiogram, Electrocardiogram, Coronary Angiogram reports Blood and Laboratory test results – CKMB, Troponin T, etc.)**

**SECTION E**      ▪ (Minimally invasive) Surgery of Aorta      ▪ Large Asymptomatic Aortic Aneurysm/ Dissection

1. Where is the exact location of the aortic lesion?

2. Was there any echocardiogram or other appropriate diagnostic imaging done to demonstrate the location of the aortic lesion?

YES  NO

If Yes, please attach the report.

3. The surgery was performed to correct for:

Aortic aneurysm /dissection  Coarctation of the aorta  
 Obstruction of the aorta  Others, please specify:

4. Please provide the details of surgery.

Surgery Date (DD/MM/YYYY)	Exact Location of The Aortic Lesion	Name of Doctor & Hospital

5. What was the surgery approach?

Thoracotomy  Intra-arterial procedure  
 Laparotomy  Catheter based techniques  
 Keyhole procedure  Laser procedure

**Please attach certified true copies of all relevant reports. (E.g. Echocardiogram, Electrocardiogram, Coronary Angiogram reports Blood and Laboratory test results – CKMB, Troponin T, etc.)**

**SECTION F**      ▪ (Hypertrophic) Cardiomyopathy      (To be completed by the cardiologist)

1. What was the underlying cause of Cardiomyopathy?

Coronary Artery Disease  Drug Abuse  
 Alcohol Misuse  Others, please specify:

2. Please state the details of the current condition in accordance with New York Heart Association Classification of Cardiac Impairment.

Class I  Class III  
 Class II  Class IV

If the patient's condition falls within Class III or Class IV, kindly elaborate on the physical impairment suffered.

3. Is the patient's condition/ impairment permanent or beyond hope of recovery with current medical knowledge and technology?

YES  NO

If Yes, please elaborate.

4. Was there echocardiogram performed?

YES  NO

If Yes, what was the ejection fraction? Please enclose all the echocardiogram report.

**Please attach certified true copies of all relevant reports (E.g. Echocardiogram, Electrocardiogram, Coronary Angiogram reports Blood and Laboratory test results – CKMB, Troponin T, etc.)**

**SECTION G      ▪ Pericardiectomy (With Surgery)**

1. Was there constriction of the heart?

YES  NO

If Yes, please provide the following details.

Onset Date (DD/MM/YYYY)	The underlying cause of the heart constriction

2. Did the patient undergo Pericardiectomy to relieve the condition?

YES  NO

3. What was the surgical approach? Please select (✓) the applicable option.

Thoracotomy  Others, please specify:

Sternotomy

Endoscopy/keyhole

4. Please select (✓) the reason(s) of the surgery done,

i. Biopsy  YES  NO

ii. Aspiration of pericardial effusion  YES  NO

**Please attach certified true copies of all relevant reports. (E.g. Echocardiogram, Electrocardiogram, Coronary Angiogram reports Blood and Laboratory test results – CKMB, Troponin T, etc.)**

**SECTION H      ▪ Insertion of Pacemaker**

**▪ Insertion of Cardiac Defibrillator**

1. Please provide the onset date of Cardiac Arrhythmia.

Day  Month  Year

2. Could the cardiac arrhythmia be treated via other methods?

YES  NO

If Yes, please provide details.

3. What was the non-medical treatment for the patient's cardiac arrhythmia?

i. Insertion of a temporary Cardiac Pacemaker  YES  NO

ii. Insertion of a temporary Cardiac Defibrillator  YES  NO

iii. Insertion of a permanent Cardiac Pacemaker  YES  NO

iv. Insertion of a permanent Cardiac Defibrillator  YES  NO

**Please attach certified true copies of all relevant reports. (E.g. Echocardiogram, Electrocardiogram, Coronary Angiogram reports Blood and Laboratory test results – CKMB, Troponin T, etc.)**

**SECTION I      ▪ Infective Endocarditis (Early / Late)**

1. Please select (✓) the type of diagnosed Infective Endocarditis.

Acute                      
Sub-acute            

2. Was blood culture(s) done?

 YES                     NO

If Yes, Was the blood cultures done more than once with the blood sample drawn &gt; 12 hours apart?

 YES                     NO

If YES, please provide the following details and attach the blood culture reports.

Procedure Date (DD/MM/YYYY)	Finding(s) (Please state the name of the microorganism(s) detected)

If NO, please provide reason(s) and state how the team derived the diagnosis.

3. Was there echocardiogram or any diagnostic test done to demonstrate the lesion(s) (i.e. valvular vegetation) &amp; the valvular incompetency(ies)?

 YES                     NO

If Yes, please provide the following details &amp; attach the report(s)

<b><u>Location of the lesion(s)</u></b> Please select (✓) the impacted heart valve(s)	i. Tricuspid valves	<input type="checkbox"/>
	ii. Bicuspid (Mithral) valves	<input type="checkbox"/>
	iii. Aortic valves	<input type="checkbox"/>
	iv. Pulmonary valves	<input type="checkbox"/>
<b><u>Valvular incompetency(ies) / lesion</u></b> Please select (✓) the applicable option(s) on the lesion(s).	i. Valvular stenosis	<input type="checkbox"/>
	ii. Valvular regurgitation	<input type="checkbox"/>
	iii. Valvular perforation	<input type="checkbox"/>
	iv. Valvular abscess/vegetation	<input type="checkbox"/>

Please state the % of the stenosis or regurgitation (compared to normal heart valves)  %

If NO echocardiogram or any diagnostic test done, please provide the reason(s).

4. Is there any prosthetic valve implanted on the patient?

 YES                     NO

If YES, please state the reason of it being done.

*Please attach all of the relevant reports (E.g. Echocardiogram, Electrocardiogram, blood culture reports & any laboratory test results, etc.)***SECTION J      ▪ Eisenmenger's Syndrome (Early / Late)**

1. Is there any cardiac defect(s) leading to Pulmonary Hypertension and reversal of flow / bidirectional shunt?

 YES                     NO

If YES, please provide details of the defect(s)

2. Has the patient's diagnosis resulted in any physical impairment which fulfills the New York Heart Association (NYHA) classification of Cardiac Impairment?

 YES                     NO

If YES, please select (✓) the applicable NYHA class &amp; elaborate the following in detail: (Please refer to the next page)

New York Heart Association (NYHA) classification	Is the physical impairment permanent?	Kindly elaborate on the physical impairment suffered.
i. Class I	<input type="checkbox"/> YES <input type="checkbox"/> NO	
ii. Class II	<input type="checkbox"/> YES <input type="checkbox"/> NO	
iii. Class III	<input type="checkbox"/> YES <input type="checkbox"/> NO	
iv. Class IV	<input type="checkbox"/> YES <input type="checkbox"/> NO	

3. Is there any diagnostic test(s) to confirm the diagnosis?

YES       NO

If YES, please state the name of the diagnostic test and the finding(s). Also, please attach the relevant report(s) to support the diagnosis.

*Please attach all of the relevant reports (E.g. Echocardiogram, Electrocardiogram, any laboratory test results, etc.)*

### SECTION K : Others Medical Information

1. Has the patient previously suffered from this illness or any related illness or any other illnesses?

YES       NO

If Yes, please provide details as required below :

Date of Consultation (DD/MM/YYYY)	Illness/ Diagnosis	Types of Treatment Received/ Details of Hospitalisation	Investigation Result	Name of Doctor & Name of Hospital/ Medical or Healthcare Facilities

2. Was the patient referred to you?

YES       NO

If Yes, please provide details below and enclose a copy of the referral letter (if any):

**Name & Address of Referral Doctor**

### SECTION L : Attending Doctor's Declaration

I hereby certify that:

I am the patient's attending doctor and I have personally examined and treated the patient for the illnesses/ injuries sustained; OR  
 I have personally perused the patient's medical records;

and that the facts as stated above are all true to the best of my knowledge and information that I have perused.

Signature : \_\_\_\_\_ Date : \_\_\_\_\_  
Name : \_\_\_\_\_  
Professional Qualification : \_\_\_\_\_  
MMC/ Registration Number : \_\_\_\_\_  
Name & Address of Hospital/ Clinic : \_\_\_\_\_  
Official Stamp of the Hospital/ Doctor : \_\_\_\_\_