CRITICAL ILLNESS CLAIM - DOCTOR'S STATEMENT

Kidney, Liver, Lung and Gastrointestinal Related Conditions

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

PRUDENTIAL

Patient's Personal Details

Name

Policy Number

NRIC/Old IC/Passport/Birth Cert/Others

Date of Birth

Gender ☐ Male ☐ Female

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

	Sections to be completed
☐ End Stage Kidney Failure	A, B, R & S
☐ Chronic Severe Renal Impairment	A, B, R & S
☐ Severe Diabetic Nephropathy resulting in Kidney Failure	A, B, R & S
☐ Systemic Lupus Erythematosus (SLE) with Lupus Nephritis	A, C, R & S
☐ Systemic Lupus Erythematosus (SLE) with Severe Kidney Complications	A, C, R & S
☐ Medulla Cystic Disease	A, D, R & S
☐ Nephrectomy/ Removal of one Kidney	A, E, R & S
☐ End Stage Liver Failure	A, F, R & S
☐ Fulminant Viral Hepatitis	A, F, R & S
☐ Cirrhosis of the Liver	A, F, R & S
☐ Autoimmune Hepatitis (Early / Chronic)	A, F, R & S
☐ Partial Hepatectomy	A, G, R & S
☐ Portal Vein Thrombosis	A, H, R & S

	Sections to be completed
☐ End Stage Lung Disease	A, I, R & S
☐ Primary Pulmonary Arterial Hypertension	A, J, R & S
☐ Surgical Removal of the Lungs (whole lung or lobes)	A, K, R & S
☐ Status Asthmaticus	A, L, R & S
☐ Surgical Insertion of a Vena-cava Filter	A, M,R & S
☐ Heart Failure due to Chronic Lung Disease	A, N, R & S
☐ Acute Necrotizing / Chronic Relapsing Pancreatitis	A, O, R & S
☐ Biliary Tract Reconstruction Surgery	A, P, R & S
☐ Chronic Primary Sclerosing Cholangitis	A, P, R & S
☐ Chronic Crohn's Disease	A, P, R & S
☐ Chronic Ulcerative Colitis	A, P, R & S
☐ Adrenalectomy For Adrenal Adenoma	A, Q, R & S
☐ Chronic Adrenal Insufficiency	A, Q, R & S

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 for 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

FORM ID 11601123

SECTION B

- **End Stage Kidney Failure**
- **Chronic Severe Renal Impairment**
- **Severe Diabetic Nephropathy resulting in Kidney Failure**

(To be completed by the Nephrologist)

1. Please provide details inclusive of first/ initial presentation (symptoms/signs), diagnosis, treatments, leading to chronic renal failure.

Date (DD/MM/YYYY)	Symptoms/ Signs	Diagnosis	Treatment

2. What is the underlying cause of Chronic Kidney Disease? Please tick the relevant and provide the date of onset.

☐ Lupus Nephritis — Day ____ Month ____ Year ____

☐ Medullary Cystic Disease — Day ____ Month ____ Year ____

☐ Diabetes Mellitus — Day ____ Month ____ Year ____

☐ Inherited/ Hereditary/ Congenital disease, Please provide details

☐ Others, please elaborate

3. What is the stage of the renal failure?

Date of the renal test was done (DD/MM/YYYY)	eGFR reading (ml/min/1.73m2)	Renal failure staging

Please attach the results of Renal Function Tests. (E.g. eGFR, bilirubin, albumin creatinine ratio) upon diagnosis of the Chronic Renal Failure and the latest results. (For at least six months from the date the chronic renal failure was first diagnosed.)

4. Is the patient currently undergoing haemodialysis or peritoneal dialysis?

☐ YES ☐ NO

If Yes, please provide details below and enclose copy of haemodialysis card or medical bill of the dialysis.

Date Started (DD/MM/YYYY)	Type of Dialysis	Frequency (No. of times per week)

5. Has renal transplantation been performed?

☐ YES ☐ NO

If Yes, please state date of renal transplantation and hospital in which it was performed.

Date Started (DD/MM/YYYY)	Hospital Name

If No, please state if renal transplantation is planned.

☐ YES, Please provide evidence of official waiting list as recipient. ☐ NO

6. Was renal biopsy done?

☐ YES ☐ NO

If Yes, please provide the biopsy reports.

Please attach certified true copies of all relevant reports. (E.g. Renal Biopsy, Blood and Laboratory test results (for SLE – blood test on antibodies), Ultrasound/ Imaging study of Kidney, Haemodialysis card, Renal Function Test with Electrolytes report (e.g. eGFR, bilirubin, albumin creatinine ratio), etc.)

SECTION C ▪ **Systemic Lupus Erythematosus (SLE) with Lupus Nephritis**
▪ **Systemic Lupus Erythematosus (SLE) with Severe Kidney Complications** ***(To be completed by the Rheumatologist)***

1. Please select the clinical manifestations exhibited by the patient.

i. Malar rash ☐
ii. Discoid rash ☐
iii. Photosensitivty ☐
iv. Oral Ulcers ☐
v. Arthritis ☐
vi. Serositis ☐
vii. Renal disorder ☐
viii. Blood disorder, (please select the applicable option(s) below) ☐
Leukopenia (<4,000/mL), or ☐
Lymphopenia (<1,500/mL), or ☐
Haemolytic anaemia, or ☐
Thrombocytopenia (<100,000/mL) ☐
ix. Positive Anti-nuclear Antibodies ☐
x. Positive L.E. cells ☐
xi. Positive Anti-DNA ☐
xii. Positive Anti-Sm (Smith IgG Auto-antibodies) ☐
xiii. Others. Please specify

2. What is the stage of the renal failure?

Date of the renal test was done (DD/MM/YYYY)	eGFR reading (ml/min/1.73m2)	Renal failure staging

3. Please confirm if the patient falls under which class according to the WHO Lupus Classification and select ONE applicable option.

☐ Class I (Minimal Change) - Negative, normal urine
☐ Class II (Mesangial) - Moderate proteinura, active sediment
☐ Class III (Focal Segmental) - Proteinura, active sediment
☐ Class IV (Diffuse) - Acute nephritis with active sediment and/or Nephritis syndrome
☐ Class V (Membranous) - Nephrotic syndrome or Severe proteinura

4. What is the current treatment?

5. Please provide the details below and enclose copies of the biopsy report and investigation reports.

Date of Biopsy (DD/MM/YYYY)	Biopsy / Investigation Result

Please attach certified true copies of all relevant reports. (E.g. Renal Biopsy, Blood and Laboratory test results (for SLE – blood test on antibodies), Ultrasound/Imaging study of Kidney, Haemodialysis card, Renal Function Test with Electrolytes report, etc.)

SECTION D ▪ **Medulla Cystic Disease**

1. Please indicate the clinical manifestation.

☐ Anaemia
☐ Polyuria
☐ Others, please specify

2. Was renal biopsy done?

☐ YES ☐ NO

If Yes, please provide the biopsy reports.

3. Please provide details inclusive of first/ initial presentation (symptoms/signs), diagnosis, treatments, leading to chronic renal failure.

Date (DD/MM/YYYY)	Symptoms/ Signs	Diagnosis	Treatment

Please enclose Renal Function Test (inclusive of eGFR, Electrolytes), Ultrasound/ Imaging studies of kidney and all relevant reports. (E.g. UFEME, ANA, anti-dsDNA, anti-SM, spot protein/creatinine ratio for SLE, etc.)

SECTION E ▪ **Nephrectomy / Removal of one Kidney**

1. Please provide details of diagnosis leading to removal of the kidney and enclose surgical report.

☐ Illness
☐ Accident

Please attach certified true copies of all relevant reports. (E.g. Renal Biopsy, Blood and Laboratory test results (for SLE – blood test on antibodies), Ultrasound/ Imaging study of Kidney, Haemodialysis card, Renal Function Test with Electrolytes report, etc.)

SECTION F ▪ **End-Stage Liver Failure (Chronic Liver Disease)** ▪ **Cirrhosis of the Liver** ▪ **Fulminant Viral Hepatitis** ▪ **Autoimmune Hepatitis (Early / Chronic)**

1. What were the sign & symptoms presented upon diagnosis? Please select the applicable option(s).

i.	Jaundice	☐ YES	☐ NO	If Yes, since when?
ii.	Ascites	☐ YES	☐ NO	
iii.	Hepatic Encephalopathy	☐ YES	☐ NO	
iv.	Portal Hypertension	☐ YES	☐ NO	
v.	Cirrhosis	☐ YES	☐ NO	
vi.	Hypergammaglobulinaemia	☐ YES	☐ NO	

2. What was the extent of the cirrhosis?

i. Whole Liver	☐ YES	☐ NO
ii. Partial Liver	☐ YES	☐ NO
iii. Local Fibrotic/ Cirrhotic changes	☐ YES	☐ NO

3. Was there liver failure?

☐ YES ☐ NO

If Yes, is the liver failure resulting from any of the following? Please select the applicable option(s).

Viral Infection	☐ YES	☐ NO
Drug	☐ YES	☐ NO
Alcohol	☐ YES	☐ NO
Attempted Suicide	☐ YES	☐ NO
Poisoning	☐ YES	☐ NO
Autoimmune	☐ YES	☐ NO
Others. Please specify		

Please specify type of virus/ drug/ substance/ auto-antibody(ies)

*if answered Yes for **autoimmune**, please select the applicable option(s),*	*if answered Yes for **the other options**, please specify the type of virus/drug/substance,*
i. Anti-nuclear antibody ☐	
ii. Anti smooth muscle antibody ☐	
iii. Anti-actin antibody ☐	
iv. Anti-LKM-1 antibody ☐	
v. Anti-CI-1 antibody ☐	
vi. Anti-SLA/LP antibody ☐	

4. Has the liver failure reached the end stage?

☐ YES ☐ NO

5. Is the encephalopathy a form of Wernicke's encephalopathy?

☐ YES ☐ NO

6. Is the liver size decreasing? If Yes, please provide series of ultrasound reports indicating the changes in the liver size details.

☐ YES ☐ NO

7. Please describe the extent of the liver necrosis and hepatocellular damage.

8. Is there a deteriorating of liver function? If Yes, Please supply the detailed results of serial liver function test results including bilirubin levels, liver biopsy and laboratory evidence as well as any other tests.

☐ YES ☐ NO

9. Please provide the scores of the liver cirrhosis based on the **HAI (Histology Activity Index)-Knodell Score** , from liver biopsy.

	Scores		Scores
i. Periportal +/- Bridging necrosis		iii. Portal Inflammation	
ii. Intralobular degeneration and Focal necrosis		iv. Fibrosis	

Please attach certified true copies of all relevant reports. (E.g. Radiological, CT scanning or Imaging reports, Liver Function Test results, Blood and laboratory test results, liver biopsy report, etc.)

SECTION G ▪ Partial Hepatectomy

1. Please provide full and exact diagnosis leading to hepatectomy, including dates of diagnosis.

Diagnosis	Diagnosis Date (DD/MM/YYYY)

2. What was the extent of the hepatectomy?

i. Segment ☐ YES ☐ NO

ii. Whole Lobe ☐ YES ☐ NO

iii. Others, please specify

3. What was the cause leading to hepatectomy?

☐ Illness ☐ Accident ☐ Organ Donation

☐ Alcohol ☐ Drug abuse ☐ Biopsy (for diagnostic purpose)

☐ Others. Please provide details,

Please attach certified true copies of all relevant reports. (E.g. Radiological, CT scanning or Imaging reports, Liver Function Test results, Blood and laboratory test results, etc.)

SECTION H ▪ Portal Vein Thrombosis

1. What was the underlying cause of the thrombosis of portal vein?

2. Did the thrombosis of the portal vein resulted in,

☐ Ascites ☐ Enlargement of the spleen ☐ Oesophageal varices

Please attach certified true copies of radiological evidence of blockage of portal vein (E.g. C.T, MRI, ultrasound, ultrasonography, etc.) and all relevant reports (E.g. Radiological, CT scanning or Imaging reports, Liver Function Test results, Blood and laboratory test results, etc.)

SECTION I ▪ End-stage Lung Disease (Chronic Lung Disease)

1. Has the lung disease reached end stage?

☐ YES ☐ NO

If Yes, please state the date.

☐ Day ☐ Month ☐ Year

2. What is the underlying cause leading to respiratory failure?

☐ Airway Disease ☐ Others, please specify.

3. What is the FEV1 test result for the past 6 months?

☐ ≥ 80% predicted value ☐ 30% ≤ FEV1 < 50% predicted

☐ 50% - 80% predicted value ☐ value <30% predicted value

4. What is the baseline Arterial Blood Gas results?

mmHg

5. Does the patient requires temporary or permanent oxygen treatment for the respiratory failure?

☐ Temporary ☐ Permanent

Please provide details on the oxygen treatment regime.

6. Is there dyspnoea at rest?

☐ YES ☐ NO

Please enclose all the relevant reports (E.g. Radiological, CT scanning or Imaging reports, Blood and laboratory test results, Surgery report or hospital reports, etc.)

SECTION J ▪ Pulmonary Arterial Hypertension (Primary or Secondary)

1. Is there any underlying cause or conditions or congenital related condition?

☐ YES ☐ NO

If Yes, please provide details.

2. What investigations were performed to determine the condition of Pulmonary Arterial Hypertension? Please state type of investigations, results and enclose copy of all investigation results.

3. Was cardiac catheterization done?

☐ YES ☐ NO

4. Is there any ventricular enlargement / hypertrophy? If Yes, please provide investigation results as reference.

☐ YES ☐ NO

5. Please state current condition of the patient in accordance with New York Heart Association or an equivalent classification of cardiac impairment.

☐ Class III ☐ Class IV ☐ Others, please specify.

6. Is the above condition (I.e. Class III or IV permanent and/ or beyond hope of recovery with current medical knowledge and technology?

☐ YES ☐ NO

7. With the Pulmonary Arterial Hypertension, is the patient able to perform his/her usual occupation?

☐ YES ☐ NO

If No, please provide the tasks that the patient is unable to perform.

Please enclose all the relevant reports (E.g. Radiological, CT scanning or Imaging reports, Blood and laboratory test results, Surgery report or hospital reports, etc.)

SECTION K ▪ Surgical Removal of the Lungs (Whole lung or lobes)

1. Please provide full and exact diagnosis leading to hepatectomy, including dates of diagnosis.

Diagnosis	Diagnosis Date (DD/MM/YYYY)

2. What was the extent of the removal done?

☐ One Lobe ☐ Two Lobes or More ☐ One Whole lung

3. Please provide details of diagnosis leading to removal of the lobe(s) of the lung(s) and enclose surgical report.

☐ Illness ☐ Liver Biopsy
☐ Accident ☐ Donation

Please enclose all the relevant reports (E.g. Radiological, CT scanning or Imaging reports, Blood and laboratory test results, Surgery report or hospital reports, etc.)

SECTION L ▪ Status Asthmaticus

1. Was the patient hospitalized due to Status Asthmaticus?

☐ YES ☐ NO

If Yes, please provide the hospitalisation dates, hospital & treating doctor.

Admission Date (DD/MM/YYYY)	Hospital	Doctor

2. Was the patient put on pressure ventilation with a mechanical ventilator?

☐ YES ☐ NO

If Yes, please specify the duration (in hours)

hours

Please enclose all the relevant reports (E.g. Radiological, CT scanning or Imaging reports, Blood and laboratory test results, Surgery report or hospital reports, etc.)

SECTION M ▪ Surgical Insertion of a Vena-Cava Filter

1. When was the patient first diagnosed of Pulmonary Embolism?

Day Month Year

2. What was the underlying cause of Pulmonary Embolism?

3. Was there recurrent Pulmonary Embolism?

YES NO

If Yes, please provide fill details on the recurrent episodes including dates of diagnosis and treatment.

Date (DD/MM/YYYY)	Treatment

4. Did the patient undergo surgery for insertion of a vena-cava filter?

YES NO

If Yes, please provide date of surgery was performed.

Day Month Year

Please enclose all the relevant reports (E.g. Radiological, CT scanning or Imaging reports, Blood and laboratory test results, Surgery report or hospital reports, etc.)

SECTION N ▪ Heart Failure Due to Chronic Lung Disease

1. The date Chronic Lung Disease was diagnosed.

Year

2. What is the underlying cause of Chronic Lung Disease?

3. Was there right or left heart failure?

Right Left

4. What was the underlying cause of the heart failure?

Heart Disease Lung Disease

Please elaborate in details.

5. Was the lung disease chronic or irreversible?

Chronic Irreversible

6. Was the Irreversible Right Ventricular Failure evidenced by

i. Pulmonary Hypertension YES NO

ii. Persistent Right Ventricular Dilatation and Hypertrophy YES NO

iii. Persistent characteristic ECG changes YES NO

Please enclose radiological evidence of blockage of portal vein (E.g. C.T, MRI, Ultrasound, Ultrasonography, etc) and all the relevant reports (E.g. Radiological, CT scanning or Imaging reports, Blood and laboratory test results, Surgery report or hospital reports, etc.)

SECTION O ▪ Acute Necrotizing Pancreatitis ▪ Chronic (Moderately) Relapsing Pancreatitis

(To be completed by the Gastroenterologist)

1. Has the patient suffered from multiple attacks of Acute Pancreatitis?

Yes No

If Yes, please provide details as required below :

Date(s) of acute attack (DD/MM/YYYY)	Presenting clinical features	Treatment / Advice (E.g. Medications, Surgery)

2. Was the pancreatic dysfunction caused by Pancreatitis?

☐ Yes ☐ No

If YES, please select (√) the applicable option(s) below,

☐ ***Endocrine insufficiency (Please proceed to question 3)***
☐ ***Exocrine insufficiency (Please proceed to question 4)***

3. Was the insulin production reduced AFTER the pancreatitis episodes(s)?

☐ Yes ☐ No

Please select (√) the applicable complication(s) from the insulin insufficiency state above,

☐ Hyperglycaemia
☐ Pre-diabetic state
☐ Diabetes Mellitus

4. Has the patient suffered from Malabsorption Syndrome?

☐ YES ☐ NO

If Yes, kindly provide details on the clinical features and attach the investigation results done to confirm on the diagnosis.

5. What caused the Pancreatitis episodes?

			If Yes, please provide the details.
a. Gallstones	☐ YES	☐ NO	
b. Alcohol	☐ YES	☐ NO	
c. Autoimmune / Inflammatory	☐ YES	☐ NO	
d. Genetic factor (E.g. Sweat test)	☐ YES	☐ NO	
e. Congenital	☐ YES	☐ NO	
f. Idiopathic	☐ YES	☐ NO	

6. Was there ERCP done to confirm on the diagnosis?

☐ YES Kindly state the finding(s) from the report & attach the imaging report.

☐ NO kindly state the reason(s) for the imaging is not being done.

7. Was the biopsy done? If Yes, please state the findings & attach copy of the biopsy report(s).

8. Is there any other information that you think will be useful to support the assessment?

SECTION P

- **Chronic Primary Sclerosing Cholangitis**
- **Biliary Tract Reconstruction Surgery**
- **Chronic Crohn's Disease**
- **Chronic Ulcerative Colitis**

1. Please select (√) the clinical symptoms manifested,

a. Abdominal pain / cramping ☐
b. Diarrhoea ☐
c. Rectal bleeding ☐
d. Jaundice ☐
e. Extra-intestinal symptoms report. ☐
Please state the symptom(s)
f. Others ☐
Please state the symptom(s)

2. Please indicate (√) the extent of the gastrointestinal tract and/or hepatobiliary tree inflammation,

a. Liver ☐
b. Biliary tree ☐
c. Duodenum ☐
d. Jejunum ☐
e. Ileum ☐
f. Ascending colon ☐
g. Transverse colon ☐
h. Descending colon ☐
i. Rectum ☐
j. Others. Please state. ☐

3. Was there any imaging (E.g. x-ray, CT scan, MRI) and endoscopic imaging(s) done?

☐ Yes ☐ No

If YES, please the name of the imaging done and the major finding(s),

Name of the imaging(s)	Finding(s)
External imaging :	
Endoscopic imaging :	

Please submit the aforementioned imaging report(s)

4. Was there any obstruction/sclerosis or perforation/fistula formed on the impacted area(s)?

☐ YES ☐ NO

If YES, please select (√) the applicable option(s) below,

☐ ***If there is obstruction/sclerosis, please proceed to question 5.***

☐ ***If there is perforation /fistula, please proceed to question 6.***

5. Please answer all of the following questions,

i. Please select (√) the relevant option for the cause of the sclerosis or obstruction,

a. Biliary tract surgery ☐

b. Gallstone ☐

c. Autoimmune ☐

d. Infection ☐

e. Inflammation ☐

f. Others ☐

Please state the infection/inflammation /other precipitant(s) which contribute to sclerosis/obstruction,

ii. Please state the area of the obstructed region(s),

iii. Is stenting / balloon dilation required to relieve the obstruction?

☐ YES ☐ NO

6. Please answer all of the following questions,

i. Please state the area of the perforated region(s),

ii. Is corrective surgery required to repair the tear?

☐ YES ☐ NO

7. Was biopsy performed?

☐ YES ☐ NO

If YES, please select (√) the applicable option(s) below,

Date (DD/MM/YYYY)	Finding(s)

8. Does the patient's condition require continuous immunosuppression or immunomodulatory therapy for at least 6 months?

☐ Yes ☐ No

9. Has the patient undergone any surgical intervention(s) as a therapeutic or preventative measures?

☐ Yes ☐ No

If YES, please select (√) the surgery(ies) done and state the medical reason(s) for the surgery conducted.

a. Partial Colectomy ☐

b. Total Colectomy ☐

c. Biliary Tract reconstructive surgery ☐

d. Small bowel resection ☐

e. Ileostomy ☐

f. Choledochoenterostomy ☐

g. Others
Please state the surgery(ies)

Please attach all of the relevant reports (E.g. blood/stool tests, biopsy reports, any imagings/endoscopy reports & any others laboratory test results, etc.)

SECTION Q ▪ **Adrenalectomy For Adrenal Adenoma** ▪ **Chronic Adrenal Insufficiency**

1. Please answer all of the following questions,

i. Was there dysfunction of the adrenal glands?

☐ Yes ☐ No

If YES, please select (√) the applicable option(s) below,

☐ ***Reduce adrenal glands' production (adrenal insufficiency)***
☐ ***Excessive adrenal glands' production (functional adrenal lesion)***
☐ ***Others, please state*** _____

ii. Please select (√) the impacted hormone(s) on the aforementioned dysfunction

Glucocorticoids	**Mineralocorticoids**	**Sex Hormone(s)**
Cortisol ☐ Corticosterone ☐	Aldosterone ☐	Androgen ☐ Progesterone ☐ Oestrogen ☐

If there is adrenal insufficiency, please proceed to question 2.
Otherwise, please proceed to question 3.

2. Please select (√) the underlying cause of the adrenal insufficiency.

☐ Primary (Autoimmune)
☐ Secondary (inflammation / infection)

Please state the underlying condition(s), _____

3. Please answer all of the following questions,

i. Please select (√) the test(s) done to derive at the diagnosis,

☐ ACTH simulation tests
☐ Insulin-induced hypoglycemia test
☐ Plasma ACTH level measurement
☐ Plasma Renin Activity (PRA) level measurement
☐ Others, please state _____

ii. Was there imaging performed?

☐ Yes ☐ No

If YES, please provide the imaging report(s) which shows the lesion(s) on the adrenal glands

4. Is the condition manageable with medications?

☐ Yes ☐ No

If YES, please select (√) the applicable option(s) below,

☐ Anti-hypertensive medications
☐ Diuretics
☐ Hormone(s) replacement therapy

If NO, please provide details on the surgical interventions done.

Date (DD/MM/YYYY)	**Surgery(ies)**

Please attach all of the relevant reports (E.g. blood tests, biopsy reports, any imagings/endoscopy reports & any others laboratory test results, etc.)

SECTION R : 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 R : 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 :