



PART II - ATTENDING PHYSICIAN'S STATEMENT (STATEMENT OF CRITICAL ILLNESS) CANCER

This report is to be completed by a registered medical practitioner at the own expense of the claimant.

Name of Patient			
Age		Policy Number	
Present Occupation		Gender	<input type="checkbox"/> Male / <input type="checkbox"/> Female

1. General Details	
a) Are you the patient's regular medical attendant?	<input type="checkbox"/> Yes, since when <input type="checkbox"/> No
b) Are the patient's have family (parents or siblings) been diagnosed or died with cancer?	<input type="checkbox"/> Yes, since when <input type="checkbox"/> No
c) When did your patient first consult you for this condition?	
d) Symptoms presented at that time	
e) Date of symptoms first appeared	According to patient: _____ In your opinion : _____
f) Please describe the exact details of your patient's present condition.	
g) Date last seen by you	

2. Diagnosis Details I	
a) Please give full details of the diagnosis.	
b) Date of diagnosis	
c) Name and address of doctor who established the diagnosis	
d) Was your patient informed of the diagnosis? If yes, when and by whom?	
e) Had your patient suffered any previous episodes of this condition or any other conditions leading to it or relating to it? If yes, please give details, including exact date of episodes or conditions.	
f) Was your patient referred to you? If yes, please give name and address of doctor concerned.	
g) Name and address of doctor(s) who attended to your patient prior to seeing you	



h) Name and address of doctor(s) who is/are treating your patient concurrently for this condition	
i) Did you refer your patient to any other doctor(s)? If yes, please provide name and address of the doctor(s).	

3. Diagnosis Details II	
a) How did you confirm the diagnosis?	
b) What was the histological diagnosis? Please enclose a copy of the histology report.	
c) Site of the tumour	
d) Stage of the tumour	i. TNM classification : _____ ii. AJCC (American Joint Committee on Cancer) Staging : _____
e) Was the cancer histologically classified as uncontrolled growth of malignant cells with invasion of tissue?	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Was the cancer/ tumour classified as the following classification?			
All skin cancers except invasive malignant melanoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Lymphocytic Leukemia less than RAI Stage 3	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pre-malignant	<input type="checkbox"/> Yes <input type="checkbox"/> No	In the presence of HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Carcinoma-in-situ	<input type="checkbox"/> Yes <input type="checkbox"/> No	All tumours of the prostate, thyroid and urinary bladder histologically classified as T1N0M0 (TNM classification)	<input type="checkbox"/> Yes <input type="checkbox"/> No

5. Treatment/ Surgery/ Future Management	
a) Date of surgery/ medical treatment	
b) Details of surgery/ medical treatment	
c) Name of hospital and doctor who performed the surgery/ medical treatment	
d) What other future management is planned for this patient?	



6. Has the patient been treated for any of the following illnesses? If yes, please provide additional information as per the table below.

	Date of diagnosis/ Onset	Name and address of Doctor(s) consulted	Dates of consultation
Unexplained weight loss of 5kg or more			
Blood in urine			
Persistent coughing			
Bleeding from the bowels or in stools			
Diarrhoea or constipation for 30 days or more			
Other illnesses/ Injuries Please specify			

7. Please give other information which you feel would be helpful in the assessment of your patient's claim.

Note: Please enclose copies of all investigation reports including biopsy, cytology reports, CT Scans, imaging studies, laboratory evidence, surgical reports and all other relevant hospital reports that are available.

I hereby certify that I *have / have not seen the claimant's Identity Card number as stated above and that the photograph of which bears resemblance to the claimant whom I have examined.

I hereby certify that the answers above are full, complete and true.

(Signature of Doctor with official hospital stamp)

Name : _____

Qualification : _____

Date : _____