ATTENDING PHYSICIAN STATEMENT (TO BE COMPLETED BY ATTENDING DOCTOR / SURGEON)

IMPORTANT NOTE

1. *The acceptance of this form is NOT an admission of liability on the part of EQ Insurance Company Limited.*
2. *Policyholder/ claimant must bear the fee charged (if any) for completion of this form.*
3. *We reserve our rights to request for claimant to submit additional information or documents, if necessary.*

Patient Full Name:	NRIC / FIN No:	Date of Birth:
Name of Hospital Admitted:	Date Admitted:	Date Discharged:

Please indicate the diagnosis of all the condition(s) treated:

What were the complaints or symptoms presented and how long has the patient been experiencing them?

Have you seen this patient prior to the above said admission? ☐ Yes ☐ No

If yes, please state the date of the first consultation: _____

Was the patient referred to you by another doctor? ☐ Yes ☐ No

If yes, please state the date of referral and provide us with the name and clinic address of the referring doctor:

_____

If no, what prompted the patient to see you?

_____

What is the cause(s) of the diagnosed condition(s) / injury?

Given the etiology of the condition and the patient's medical history provided to you, please state the estimated duration of such condition would be in existence:

Has the patient ever had the same or any similar condition(s)? ☐ Yes ☐ No ☐ Not to my knowledge

If yes, please state:

Date(s) of consultation: _____

Name(s) and Address(es) of the doctor who treated the patient previously: _____

_____

Type of operation / surgical procedure(s) performed: _____

Date performed: _____

Type of operation / surgical procedure(s): _____

TOSP code: _____

If 2 or more surgeries were performed, please specify whether they were done through same incision?

If no surgery was performed, please state type of treatment / medication given to the patient.

Is the diagnosed condition(s) / treatment due to or associated with any of the following?

Pregnancy, infertility, childbirth, birth control, miscarriage or abortion	☐ Yes	☐ No
Congenital condition / Birth Defects	☐ Yes	☐ No
Genetic	☐ Yes	☐ No
Hereditary	☐ Yes	☐ No
Cosmetic surgery	☐ Yes	☐ No
Dental care or treatment	☐ Yes	☐ No
Mental / Psychiatric disorder	☐ Yes	☐ No
Effect of influence of alcohol or drug	☐ Yes	☐ No
Self-inflicted injuries / attempted suicide	☐ Yes	☐ No
Sexually transmitted disease (STD / STI)	☐ Yes	☐ No
AIDS or any illness caused by or related to HIV	☐ Yes	☐ No
Sleep Apnea / Sleep Disorder	☐ Yes	☐ No

To your best knowledge, is the patient suffering / has suffered from any other significant illness or have any other medical conditions which could have contributed to the present illness / injury? ☐ Yes ☐ No

If no, please specify the illness / medical conditions: _____

Bearing in the mind the patient's occupation, do you feel that the illness / injury would have prevented him from working? ☐ Yes ☐ No

How long was, or will the patient be totally and continually disabled (unable to work?): _____

How long was, or will the patient be partially disabled? _____

Is the patient still under your care for this condition? ☐ Yes ☐ No

Has the patient been referred to another doctor for follow-up treatment? ☐ Yes ☐ No

Please provide the name and clinic address of the doctor: _____

Please provide any other information that you feel with be helpful to us in the assessment of this claim. Please enclose copies of all investigation reports (e.g. laboratory, histopathology, imaging etc.), if any.

I hereby certify that I have personally examined and treated the patient in connection to the above condition(s). I declare that the above answers are true to the best of my knowledge and belief.

Signature of Attending Doctor / Surgeon

Date

Name of Attending Doctor / Surgeon

Hospital / Clinic stamp

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