HSBC Life

Attending Physician Statement - Bacterial Meningitis

Instruction to doctor: This patient is insured with us against the happening of certain contingent events associated with his health. A claim has been submitted in connection with Bacterial Meningitis. To enable us to assess the claim, please complete this report and return it directly to our company. For questions where date is applicable, please complete in the format of day/month/year.

To be completed and signed by the Attending Physician

I hereby certify that I personally examined the patient and my records and medical opinion are as follows:

1. Name of patient: _____ NRIC no. : _____

2. Are you the patient's regular medical attendant? ☐ Yes ☐ No
   If yes, please provide details beginning with the first record in your clinic:

Date(s) consulted	Purpose & details of Consultation(s)	Diagnosis	Nature of treatment rendered, including type of tests and/or surgeries done

If no, do you know the name and address of the patient's regular medical attendant(s)?
☐ Yes ☐ No

If yes, please provide details:

Name of medical attendant	Address

3. Details of the consultation

3.1 Date you were first consulted for Bacterial Meningitis: _____

a. State the symptoms presented, the medical history as presented by the patient and date when the symptoms first appeared.

Symptoms Presented at first consultation	Date symptoms first started

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b. Where is the source of this information about the patient's condition? (Patient or referring doctor or others. If others, please specify)

_____

c. In your opinion, how long do you think the symptoms first appeared prior to consulting you?

_____

d. If the patient was referred to you OR if the patient had seen other doctor(s) before consulting you for this medical condition or its symptoms, please provide details:

Name of doctor(s) or hospital(s)	Address of doctor(s) or hospital(s)	Date consulted or date referred to you

(Please continue with your documentation on a blank page if there are more than 3 records and attached it with this report)

4. Details of the illness

4.1 Details of diagnosis:

Doctor's diagnosis	
Diagnosis date	
Underlying cause (if any)	

4.2 Date of when patient was first informed of the diagnosis: _____

4.3 Name of doctor or hospital who first made the diagnosis:

_____

4.4 Has the patient previously suffered from the same condition or any related illnesses?

☐ Yes ☐ No

If yes, please provide details.

_____

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4.5 Does the patient's bacterial infection resulting in severe inflammation of the membranes of the brain? ☐ Yes ☐ No
If Yes, please provide us a copy of the laboratory test result

4.6 Does the patient's bacterial infection resulting in severe inflammation of the spinal cord? ☐ Yes ☐ No

4.7 Was there any medical procedure of lumbar puncture done? ☐ Yes ☐ No
If Yes, please advise whether there is presence of bacterial infection in cerebrospinal fluid? ☐ Yes ☐ No
Please also provide us a copy of the laboratory test result which showed presence of bacterial infection in cerebrospinal fluid by lumbar puncture

4.8 Is the patient's condition in any way related or due to:

a. AIDS or HIV related illness? ☐ Yes ☐ No
b. Use of drug not prescribed by a registered medical practitioner or drug abuse? ☐ Yes ☐ No
c. Alcohol related brain damage? ☐ Yes ☐ No
d. Congenital anomaly or defect? ☐ Yes ☐ No

If yes, please provide details and enclose a copy of the test result:

Diagnosis date	
Name and address of doctor who first diagnosed the patient with the above conditions	

5. Details of treatment and surgery

5.1 State the full details of all treatment provided (example medication, therapy, etc.).

Nature of treatment	Date(s) of treatment

5.2 Was there any surgery performed or going to be performed? ☐ Yes ☐ No

If yes, please provide details and enclose a copy of the operation report:

Nature of surgery performed or going to be performed	Date(s) of surgery

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5.3 Please describe fully the nature and severity of the patient's current physical disabilities and neurological limitations.

_____

5.4 How long has the neurological deficit lasted since the initial episode? Please provide its duration in weeks.

_____

5.5 Are these neurological deficits likely to be permanent and irreversible? ☐ Yes ☐ No
If yes, please provide details.

_____

5. 6 Please state the progress of recovery of the patient
☐ Recovered ☐ Improving ☐ Stationary ☐ Retrogressed

5.7 Does the patient has full power of all limbs? ☐ Yes ☐ No
If No, please state which limb(s) do not have full power and state the current power of the affected limb(s).

_____

6. Regarding the patient's medical history

6.1 Has this patient *previously* suffered from the same condition or any related illnesses? ☐ Yes ☐ No
If yes, please provide details:

Date of when condition was first diagnosed	
Resulting diagnosis	
Name and address of doctor who attended to patient (if not attended to by you)	

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6.2 Is the patient suffering from or suffered from any other medical conditions? ☐ Yes ☐ No

If yes, please provide details:

Name of doctor(s) or hospital(s) & Address	Diagnosis	Diagnosis date	Nature of treatment rendered, including type of tests and/or surgeries done

(Please continue with your documentation on a blank page if there are more than 3 records and attached it with this report)

6.3 Please provide details of the patient's habits in relation to cigarette smoking, including the duration of the smoking habit, number of cigarettes smoked per day and source of information.

_____

6.4 Please provide details of the patient's habits in relation to alcohol consumption, including the amount of alcohol consumption per day and source of information.

_____

7. Please provide us with any other additional information that will enable us in assessing this claim.

_____

_____ _____

Date Name and signature of doctor

_____ _____

Address and official stamp Qualifications