HSBC Life

Attending Physician Statement - Coma or Severe Epilepsy

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 Coma or Severe epilepsy. 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 the condition which led to coma or severe epilepsy:

_____

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3.2 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

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

_____

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

_____

3.5 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: _____

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

_____

4.4 Is the patient's condition caused by an accident? ☐ Yes ☐ No
If yes, please provide details:

Date and time of accident	
Place of accident	
Description of how the accident happened	
Extent of injuries and any other external visible injuries	

4.5 to 4.9 are additional questions for coma

4.5 Date of onset of coma: _____

4.6 Does the patient have any response to external stimuli since the onset of coma?
☐ Yes ☐ No

4.7 If no, how many hours was the patient in a state of coma with no response to external stimuli?

_____

4.8 Was the patient put on life support measures to sustain life? ☐ Yes ☐ No
If yes, please provide details:

Details of the life support measures	
Period which the patient was put on life support measures	

4.9 Has the patient emerged from the coma? ☐ Yes ☐ No
If yes, please provide the date and time when the patient emerged from the coma.

_____

If no, please provide the date of your last assessment of the patient which he remains in comatose state.

_____

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4.10 Is there any form of brain damage resulting in permanent neurological deficit being assessed at least 30 days after the onset of the coma? ☐ Yes ☐ No
If yes, please provide details:
(a) What are the neurological deficit(s) which the patient continued to present?

_____

(b) Date of your assessment made on the above deficits.

_____

4.11 to 4.16 are additional questions for severe epilepsy

4.11 Has the patient experienced recurrent unprovoked tonic-clonic or grand mal seizures, and be known to be resistant to optimal therapy as confirmed by drug serum-level testing? ☐ Yes ☐ No
If yes, please provide the details:

Date(s) of attack(s)	
Number of attack(s) per week	

4.12 Is the epilepsy due to febrile seizures alone? ☐ Yes ☐ No

4.13 Is the epilepsy due to febrile OR absence (petit mal) seizures alone? ☐ Yes ☐ No

4.14 Is the epilepsy confirmed by the use of electroencephalography (EEG), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET) or any other appropriate diagnostic test? ☐ Yes ☐ No
If yes, please state the test results and enclose copies all test results.

_____

4.15 Please provide the name of anti-epileptic (anti-convulsant) medications prescribed to the patient.

_____

4.16 What is the recommended duration that patient is required to take the prescribed medication(s) as stated in Question 4.15

_____

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4.16 Was the above diagnosis supported by histological, radiological or laboratory evidence and confirmed by a specialist of the relevant field? ☐ Yes ☐ No

(a) If yes, please state mode of investigation done to establish the above diagnosis and attach copies of histological, radiological, laboratory results and operation reports.

_____

(b) If no, why and on what basis did you derive at such diagnosis?

_____

4.17 Is the patient's condition or surgery performed 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 abuse? ☐ Yes ☐ No

(d) Attempted suicide or self-inflicted injuries? ☐ Yes ☐ No

(e) Provoked assault? ☐ Yes ☐ No

(f) Medically induced coma? ☐ Yes ☐ No

(g) Congenital anomaly or defect? ☐ Yes ☐ No

If yes to any of the above, 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 condition	

5. Details of treatment and surgery

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

Nature of treatment	Date(s) of treatment

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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

5.3 Patient's response to the treatment: _____

5.4 Was the patient referred to other doctor(s) for follow up or further management? ☐ Yes ☐ No
If yes, please state name and address of doctor(s) or hospital(s) and the reason(s) for referral.
_____

5.5 Is the patient still on follow up treatment with you? ☐ Yes ☐ No
If yes, please state the follow up treatment plan.

_____

5.6 to 5.8 are additional questions for severe epilepsy

5.6 Has patient undergone any form of neurological surgery for treatment of epileptic seizures? ☐ Yes ☐ No
If yes, please provide details under 5.1.

5.7 Is the patient taking prescribed anti-epilepsy (anti-convulsant) medication? If yes, please provide details: ☐ Yes ☐ No

Type(s) of each medication prescribed	
Period which the patient has been taking the medication	From To

5.8 Would you consider the patient to be on optimal drug therapy? ☐ Yes ☐ No
If yes, please provide details.

_____

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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).	

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 4 records and attached it with this report)

6.3 Is there anything in the patient's personal medical history which would have increased the risk of coma or epilepsy? ☐ Yes ☐ No
If yes, please provide full details, including the date of diagnosis, name and address of attending doctor and source of information.

_____

6.4 Is there anything in the patient's family history which would have increased the risk of coma or epilepsy? ☐ Yes ☐ No
If yes, please provide full details, including relationship, nature of illness, date of diagnosis and source of information.

_____

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6.5 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.

_____

6.6 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