HSBC Life

Attending Physician Statement - Coronary Artery Disease / Coronary Artery Surgery

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 Coronary artery disease / Coroner artery surgery / angioplasty & other invasive treatment for coronary artery. 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 coronary artery disease: _____

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

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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: _____

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

_____

4.4 Was there narrowing of the lumen of the coronary artery(ies)? ☐ Yes ☐ No
If yes, please provide details:

Coronary artery involved	Degree (percentage) of narrowing

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4.5 Was the diagnosis of the narrowing or blockage of the coronary arteries supported by coronary arteriography, angiographic evidence or any other appropriate diagnostic test that is available and confirmed by a cardiologist? ☐ Yes ☐ No

(a) If yes, please state mode of investigation done to establish the above diagnosis and attach copies of the coronary arteriography, angiographic evidence, operation reports and any other diagnostic test results.

_____

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

_____

4.6 Was there a current history of typical ischaemic chest pain? ☐ Yes ☐ No

4.7 Were there any changes in the ECG indicative of new myocardial infarct? ☐ Yes ☐ No

4.8 Was there any elevation of cardiac enzyme CK-MB? ☐ Yes ☐ No

4.9 Was there a diagnostic elevation of Troponin (T or I)? ☐ Yes ☐ No

4.10 Was there diagnostic elevation of any other cardiac enzymes? ☐ Yes ☐ No

4.11 Was there death of a portion of the heart muscle? ☐ Yes ☐ No

4.12 Was there left ventricular ejection fraction of less than 50% measured three months or more after the event? ☐ Yes ☐ No

If you had ticked "Yes" for Q4.6 to 4.12, please provide date of test and copies of the test results.

4.13 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) 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	

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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

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 Did patient undergo transmyocardial Laser Therapy for treatment of refractory angina which has persisted? ☐ Yes ☐ No

(a) Was patient given optimal medical therapy i.e. ACE Inhibitors/ Beta Blockers etc prior to transmyocardial Laser Therapy? ☐ Yes ☐ No

5.4 Was it an open-chest surgery to correct the narrowing or blockage of the coronary arteries with bypass graft? ☐ Yes ☐ No
If yes, please state the number and sites of grafts inserted.

_____

5.5 If open chest surgery was not performed, was any of the following procedure done?

(a) Port Access or Keyhole cardiac surgery ☐ Yes ☐ No

(b) Coronary Atherectomy ☐ Yes ☐ No

(c) Myocardia laser revascularisation ☐ Yes ☐ No

(d) Enhanced external counter pulsation ☐ Yes ☐ No

(e) Angioplasty ☐ Yes ☐ No

(f) Coronary Artery Bypass Grafting (CABG) ☐ Yes ☐ No

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5.6 If balloon angioplasty, atherectomy, laser treatment, or any similar intra arterial catheter procedure was done, please provide details on the following:

(a) Was such treatment/procedure done due to prophylactic purposes? ☐ Yes ☐ No

(b) Were the symptoms sufficiently severe to indicate that the patient's future level of exercise tolerance would be restricted at a minimal level to prevent further episodes of chest pain? ☐ Yes ☐ No

(c) Was there a specialist medical opinion which defines the need to limit exercise so as to minimise moderate to severe anginal pain? ☐ Yes ☐ No

(d) Has the patient been prescribed anti-anginal medication to limit chest pain for a minimum period of 6 months? ☐ Yes ☐ No

(e) Was the surgery performed considered medically necessary by a consultant cardiologist? ☐ Yes ☐ No

5.7 Patient's response to the treatment: _____

5.8 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.

_____

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

_____

6. Regarding the patient's medical history

6.1 Has this patient *previously* suffered from the same condition or any related illnesses such as hypertension, diabetes, hyperlipidemia, angina or other cardiovascular diseases? ☐ Yes ☐ No

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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 3 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 coronary artery disease such as hypertension, diabetes, hyperlipidemia or other heart diseases? ☐ 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 coronary artery disease? ☐ Yes ☐ No
If yes, please provide full details, including relationship, nature of illness, date of diagnosis and source of information

_____

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.

_____

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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