HSBC Life

Attending Physician Statement - Major Organ / Bone Marrow Transplantation

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 Major organ / Bone marrow transplantation. 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 illness which culminated in transplantation.

_____

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

HSBC Life

Attending Physician Statement - Major Organ / Bone Marrow Transplantation

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 of the underlying disease leading to major organ/bone marrow transplant	
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 Prior to transplantation,

(a) If human organs such as heart, lung, liver, kidney or pancreas is involved, was there irreversible end-stage failure of the relevant organ? ☐ Yes ☐ No

(b) If cornea is involved, was there irreversible scarring of the cornea and resulted in reduced visual acuity that cannot be corrected with other methods? ☐ Yes ☐ No

_____

HSBC Life

Attending Physician Statement - Major Organ / Bone Marrow Transplantation

4.5 Was the diagnosis supported by 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 blood tests, laboratory results, operation reports and other diagnostic test results.

_____

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

_____

4.6 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/misuse? ☐ Yes ☐ No

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

(e) Attempted suicide or self-inflicted injuries? ☐ 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)

Nature of treatment	Date(s) of treatment

5.2 Was there a major organ/bone marrow transplantation performed or going to be performed? ☐ Yes ☐ No

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

Type of transplantation performed or going to be performed	
Date(s) of receipt of transplantation	
Name of the doctor who performed the surgery	
Name and address of the hospital where the surgery was performed	

HSBC Life

Attending Physician Statement - Major Organ / Bone Marrow Transplantation

5.3 Was it a major organ transplant? ☐ Yes ☐ No
If yes, please provide details.

(a) State the organ transplanted: _____

(b) Was the entire organ or part of the organ transplanted? ☐ Yes ☐ No

5.4 (a) Was it a bone marrow transplant? ☐ Yes ☐ No

(b) Is the source of transplanted bone marrow obtained from another human bone marrow? ☐ Yes ☐ No

5.5 (a) Was it a bowel transplant? ☐ Yes ☐ No
(b) Is patient's bowel transplant resulted from intestinal failure? ☐ Yes ☐ No
(c) Is the source of transplanted bowel obtained from patient's own blood supply via laparotomy? ☐ Yes ☐ No
(d) What is the length of the graft (in meter) required for patient's transplant? ☐ Yes ☐ No

5.6 (a) Was it a cornea transplant? ☐ Yes ☐ No
If yes, was it a partial or whole cornea transplant?
❑ Partial ❑ Whole

(b) Was the cornea transplant due to irreversible scarring with resulting reduced visual acuity which cannot be corrected with other methods? ☐ Yes ☐ No

5.7 Was it the first graft? ☐ Yes ☐ No

If no, please give date of the first graft: _____

5.8 For how long was the patient on a waiting list for the operation? Since : _____

5.9 Prior to transplantation,

(a) What medical treatment or replacement therapy had the patient been receiving, e.g. dialysis, blood transfusions?

_____

(b) When did such treatment commence?

_____

HSBC Life

Attending Physician Statement - Major Organ / Bone Marrow Transplantation

5.10 Was the surgery performed considered medically necessary by a specialist of the relevant field? ☐ Yes ☐ No

5.11 Patient's response to the treatment: _____

5.12 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.

_____

5.13 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? ☐ 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 3 records and attached it with this report)

HSBC Life

Attending Physician Statement - Major Organ / Bone Marrow Transplantation

6.3 Is there anything in the patient's personal medical history which would have increased the risk of the illness leading to major organ/bone marrow transplant? ☐ 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 the illness leading to major organ/bone marrow transplant? ☐ 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.

_____

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