HSBC Life

Attending Physician Statement - Medullary Cystic Disease

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 Medullary Cystic Disease / Surgical removal of kidney/ renal. 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 renal disease or injury: _____

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	

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 Is/are there any cyst(s) in the renal medulla? ☐ Yes ☐ No
If Yes,
is/are the cyst(s) accompanied by the presence of tubular atrophy ☐ Yes ☐ No
is/are the cyst(s) accompanied by the presence of interstitial fibrosis ☐ Yes ☐ No

4.5 Is there clinical manifestations of anemia? ☐ Yes ☐ No
4.6 Is there clinical manifestations of polyuria? ☐ Yes ☐ No
4.7 Is there progressive deterioration in kidney function? ☐ Yes ☐ No
4.8 Is the diagnosis of Medullary Cystic Disease confirmed by renal biopsy? ☐ Yes ☐ No
If yes, please provide a copy of the renal biopsy report

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4.9 Is/are the kidney cyst(s) benign or isolated? ☐ Yes ☐ No

4.10 Please state which kidney is involved (right, left or both): _____

4.11 Is there chronic and irreversible renal failure of BOTH kidneys? ☐ Yes ☐ No
If yes, since when? _____

4.12 Is the renal failure of BOTH kidneys at its end-stage? ☐ Yes ☐ No

If yes, since when? _____

4.13 Please provide full details on the current state of the patient's renal condition and date of such assessment.

_____

4.14 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 ultrasound, histological, radiological, laboratory results and operation reports.

_____

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

_____

4.15 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 related brain damage? ☐ 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	

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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 Is the patient currently undergoing regular peritoneal dialysis or haemodialysis? ☐ Yes ☐ No

If yes, please provide details:
(a) Commencement date of first dialysis: _____

(b) Number of dialysis per week: _____

5.3 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

5.4 Was the affected kidney entirely surgically removed? ☐ Yes ☐ No
If yes, please provide details:
(a) Which kidney was completely removed (right, left or both)?

_____

(b) Is the complete surgical removal of the kidney(s) absolutely necessary? ☐ Yes ☐ No

5.5 Has renal transplantation been performed? ☐ Yes ☐ No

_____

5.6 Patient's response to the treatment: _____

5.7 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.

_____

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5.8 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 any renal diseases 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)

6.3 Is there anything in the patient's personal medical history which would have increased the risk of renal disease? ☐ Yes ☐ No
If yes, please provide details, 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 renal disease? ☐ 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