



**AVIVA LTD**

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**DREAD DISEASE CLAIM – PHYSICIAN’S STATEMENT**

Please complete all the sections in this report to the best of your knowledge. Any medical report fee will be borne by the claimant. In order for a claim under this Policy condition to be considered, the following definition must be satisfied: -

**CORONARY ARTERY BY-PASS SURGERY**

The actual undergoing of open-chest surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts. The diagnosis must be supported by angiographic evidence of significant coronary artery obstruction and the procedure must be considered medically necessary by a consultant cardiologist.

Angioplasty and all other intra arterial, catheter based techniques, “keyhole” or laser procedures are excluded.

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Name of Patient : \_\_\_\_\_ Sex: M / F Age: \_\_\_\_\_  
 NRIC/Passport No.: \_\_\_\_\_ Date of Birth : \_\_\_\_\_  
 Company : \_\_\_\_\_ Occupation : \_\_\_\_\_

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**PART A - PATIENT HISTORY**

- 1) Please state over what period do your records extend:
  - a) Date of first consultation:
  - b) Date of last consultation:
  - c) Number of consultations during the above period:
  - d) What were the reasons of consultations (with dates)?

- 2) Are you the patient’s usual doctor? **YES / NO**
  - (a) If “Yes”, since what date?

(b) If “No”, please advise the name of the regular attending doctor and address of clinic / hospital.

Signature of Physician.....  
CABG APS 250507

- 3) Was the patient referred to you? **YES / NO**  
 (a) If "Yes", please advise (i) date referred, (ii) reason the patient was referred, (iii) name of doctor recommending the referral, and (iv) name and address of clinic / hospital.
- (b) If "No", how did he / she come to consult at your clinic or hospital (e.g. A&E)?
- 4) Have you referred the patient to any other doctor(s)? **YES / NO** If "Yes", please state (a) date referred, (b) reasons for referral, (c) name of doctor(s) referred to, and (d) address of clinic/hospital.
- 5) Besides Coronary Artery Disease, does the patient have or ever have had any significant health conditions, medical history or any illness (e.g. diabetes mellitus, hypertension, hyperlipidaemia, angina, transient ischaemic attack or any other vascular disease, etc)? **YES / NO** If "Yes", please advise:
- a) Details of Symptoms      Exact Diagnosis      Date of Diagnosis      Treatment
- b) Name of the Doctor(s) (and Clinic Address) whom the patient consulted for the condition(s) stated in (a) above
- c) What is your source of the above information?
- 6) Are you aware of any members of the patient's family having suffered from any cardiovascular, renal disease, hypertension, diabetes mellitus, neurological or musculoskeletal disorder? **YES / NO** If "Yes", please advise which family members, nature of illness and date of diagnosis.

- 7) Please give details of the patient's habits in relation to past and present **smoking**, including the duration of smoking habits, number of cigarettes smoked per day and source of this information.
  
- 8) Please give details of the patients' habits in relation to **alcohol consumption**, including the amount of alcohol consumption per day and the source of this information.

**PART B - CONSULTATION FOR PRESENT ILLNESS/INJURY(IES)**

- 1) Are you aware that the patient suffered from Coronary Artery Disease? **YES / NO**
  
- 2) a) Date the patient FIRST noticed symptoms of Coronary Artery Disease:  
  
b) What symptoms did the patient notice then?  
  
  
  
c) Date the patient FIRST consulted a doctor for the symptoms:  
  
  
  
3) a) Date you first attended to the patient for Coronary Artery Disease and / or symptoms related to it:  
  
b) Details of the symptoms presented when the patient first consulted you:  
  
  
  
c) Duration of symptoms:  
(i) According to the patient:  
  
(ii) In your opinion:  
  
d) Underlying cause(s) of the symptoms:  
  
  
  
e) Exact diagnosis of the condition:



9) Has the patient suffered from any complications arising from or related to Coronary Artery Disease (e.g. hypertension, epilepsy, etc.)? **YES / NO** If yes, please provide details, including date of diagnosis and treatment prescribed.

10) Have any other investigative tests or procedure been performed? **YES / NO** If "Yes", please give details or copies of results.

11) What is the prognosis?

12) Please describe and elaborate on the nature and severity of the patient's disability and limitation, if any.

13) Is the patient still on follow-up? **YES / NO**

a) If "Yes", please advise date of last and next appointment:

b) If "No", please advise date of discharge:

14) Are you aware of any other doctors (in Singapore or overseas) whom the patient consulted for the above illnesses or any other cardiovascular diseases? **YES / NO** If "Yes", please advise:

Name of Doctor and Name &  
Address of Clinic / Hospital

Date of First & Last  
Consultation

Reason &  
Treatment

15) Had the patient ever been hospitalised before? **YES / NO** If "Yes", please advise:

<u>Name of hospital</u>	<u>Reason &amp; Treatment</u>	<u>Date of Admission &amp; Discharge</u>
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16) Please state and attach copies of all reports such as specialist or hospital reports and investigation reports (resting ECGs, Exercise stress tests, cardiac enzyme assays, coronary angiography, echocardiography, surgical reports, X-rays, CT scans, myocardial perfusion scans, and any other imaging studies, laboratory evidence, etc).

17) Do you have any other information that may be important for our assessment of the claim? **YES / NO** If "Yes", please provide details.

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Signature of Physician : .....

Name of Physician : .....

Designation : .....

Clinic's Address & Stamp: .....

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Date : .....