



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 to be considered, either of the following definitions must be satisfied: -

HEART ATTACK

Definition A

Death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. A positive diagnosis of a heart attack must be supported by the following:

- a) A history of typical chest pain;
- b) New electrocardiographic changes suggestive of myocardial infarction; and
- c) A current elevation of cardiac enzymes.

Definition B

Death of a portion of the heart muscle arising from inadequate blood supply to the relevant area. The diagnosis must be supported by three (3) or more of the following five (5) criteria which are consistent with a new heart attack:

- a) a history of typical chest pain;
- b) new electrocardiogram (ECG) changes proving infarction;
- c) diagnostic elevation of cardiac enzyme CK-MB;
- d) diagnostic elevation of Troponin (T or I); or
- e) left ventricular ejection fraction less than fifty percent (50%) measured three (3) months or more after the event.

Name of Patient : _____ Sex: M / F Age: _____

NRIC/Passport No.: _____ Date of Birth : _____

Company : _____ Occupation : _____

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.

- 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 advise (a) date referred, (b) reasons for referral, (c) name of doctor(s) referred to, and (d) address of clinic/hospital.
- 5) Besides Heart Attack, 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 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 patient's 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 Heart Attack? **YES / NO**
- 2) a) Date the patient FIRST noticed symptoms of Heart Attack:
- 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 Heart Attack 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:

- 4) Date Heart Attack condition was FIRST diagnosed:

- 5) Name of the doctor and address of hospital / clinic who made the FIRST diagnosis of the condition.

- 6) Was the patient informed of the above diagnosis? **YES / NO**
 - a) If "Yes", date the patient was first informed of the above diagnosis?

 - b) If "No", why not?

- 7) Please describe:
 - a) Initial episode of Heart Attack:

 - b) Date of initial episode:

 - c) Duration of acute symptoms:

- 8) Was there a current history of typical Ischaemic chest pain? **YES / NO** If "Yes", please give the date(s) and details of any chest pain which the patient experienced at the time of or prior to his / her myocardial infarction.

- 9) Were there any changes in the ECG indicative of ***new*** myocardial infarct? **YES / NO** If "Yes", please give the dates and specific results of all ECG's performed, and what changes were present at that time. Please attach all copies of the tracings.

- 10) Was there a diagnostic elevation of Troponin (T or I)? **YES / NO** If "Yes", please provide date of test and test results.

- 11) Was there a diagnostic elevation of Cardiac Enzyme CK-MB? **YES / NO** If "Yes", please provide date of test and test results.

- 12) Was there diagnostic elevation of any other cardiac enzymes? **YES / NO** If “Yes”, please give details of type, date of test and test results.
- 13) Was there death of a portion of the heart muscle? **YES / NO** If “Yes”, please provide details.
- 14) Was there left ventricular ejection fraction of less than fifty percent (50%) measured three months or more after the event? **YES / NO** If “Yes”, please provide date of test and test results.
- 15) Has the patient previously suffered from a Heart Attack? **YES / NO** If “Yes”, please describe in details, including date of diagnosis, name and address of the attending doctor.
- 16) Please provide full details of any other treatment provided including date of operation or procedures and his / her response.
- 17) 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.
- 18) What is the prognosis?
- 19) Please describe and elaborate on the nature and severity of the patient’s disability and limitation, if any.

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

<u>Name of Doctor and Name & Address of Clinic / Hospital</u>	<u>Date of First & Last Consultation</u>	<u>Reason & Treatment</u>
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21) Had the patient ever been hospitalised before? **YES / NO** If "Yes", please advise:

<u>Name of hospital</u>	<u>Reason & Treatment</u>	<u>Date of Admission & Discharge</u>
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22) Please state and attach copies of all reports such as specialist or hospital reports and investigation reports (resting ECG, exercise stress tests, cardiac enzymes assays, isotope imaging, coronary and LV angiography, echocardiography, myocardial perfusion scans, etc).

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

Signature of Physician :

Name of Physician :

Designation :

Clinic's Address & Stamp:

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Date :