



Part II – Attendance Physician’s Statement (Statement of Critical Illness)

CANCER

This report is to be completed by a registered medical practitioner at the own expense of claimant.

PATIENT DETAILS

Name (Last Name, First Name, M.I.)		Policy No.
Date of Birth (MMDDYYYY)		
Present Occupation	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	

I. GENERAL DETAILS

a.) Are you the patient’s regular medical attendant?	<input type="checkbox"/> Yes, since when	<input type="checkbox"/> No
b.) Is the patient a smoker?	<input type="checkbox"/> Yes, since when	<input type="checkbox"/> No
c.) Have any of the patient’s parents or siblings been diagnosed with, or passed away due to, cancer?	<input type="checkbox"/> Yes, since when	<input type="checkbox"/> No
d.) When did the patient first consult you for this condition?		
e.) Symptoms presented at that time		
f.) Date of symptoms first appeared	According to patient : _____	In your opinion : _____
g.) Please describe the exact details of your patient’s present condition.		
h.) Date last seen by you		

II. DIAGNOSIS DETAILS I

a.) Please give full details of the diagnosis.	
b.) Date of diagnosis	
c.) Name and address of doctor who established the diagnosis	
d.) Was your patient informed of the diagnosis? If yes, when and by whom?	
e.) Had your patient suffered any previous episodes of this condition or any other conditions leading to it or relating to it? If yes, please give details, including exact date of episodes or conditions.	
f.) Was the patient referred to you? If yes, please give name and address of referring doctor.	
g.) Name and address of doctor(s) who attended to your patient prior to seeing you	
h.) Name and address of doctor(s) who is/are treating your patient concurrently for this condition	
i.) Did you refer your patient to any other doctor(s)? If yes, please provide name and address of the doctor(s).	

FRAUD WARNING:

Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who represents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim.

III. DIAGNOSIS DETAILS II

a.) How did you confirm the diagnosis?	
b.) What was the histological diagnosis? Please enclose a copy of the histology report.	
c.) Site of the tumor	
d.) Stage of the tumor	i. TNM classification : _____ ii. AJCC (American Joint Committee on Cancer) Staging : _____
e.) Was the cancer histologically classified as uncontrolled growth of malignant cells with invasion of tissue?	<input type="checkbox"/> Yes <input type="checkbox"/> No

IV. WAS THE CANCER/TUMOR CLASSIFIED AS THE FOLLOWING CLASSIFICATION?

All skin cancers except invasive malignant melanoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Lymphocytic Leukemia less than RA1 Stage 3	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pre-malignant	<input type="checkbox"/> Yes <input type="checkbox"/> No	In the presence of HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Carcinoma-in-situ	<input type="checkbox"/> Yes <input type="checkbox"/> No	All tumors of the prostate, thyroid and urinary bladder histologically classified as T1N0M0 (TNM classification)	<input type="checkbox"/> Yes <input type="checkbox"/> No

V. TREATMENT/SURGERY/FUTURE MANAGEMENT

a.) Date of surgery/ medical treatment	
b.) Details of surgery/ medical treatment	
c.) Name of hospital and doctor who performed the surgery/ medical treatment	
d.) What other future management is planned for this patient?	

VI. HAS THE PATIENT BEEN TREATED FOR ANY OF THE FOLLOWING ILLNESSES? IF YES, PLEASE PROVIDE ADDITIONAL INFORMATION AS PER THE TABLE BELOW

	Date of diagnosis/ Onset	Name and address of doctor(s) consulted	Dates of consultation
Unexplained weight loss of 5kg or more			
Blood in urine			
Persistent coughing			
Bleeding from the bowels or in stools			
Diarrhea or constipation for 30 days or more			
Other illnesses/ Injuries Please specify			

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VII. PLEASE GIVE OTHER INFORMATION WHICH YOU FEEL WOULD BE HELPFUL IN THE ASSESSMENT OF YOUR PATIENT’S CLAIM

[Empty box for providing additional information]

Note: Please enclose copies of all investigation reports including biopsy, cytology reports, CT scans, imaging studies, laboratory evidence, surgical reports and all other relevant medical reports that are available.

I hereby certify that I have seen the claimant’s Identity Card number as stated above and that the photograph of which bears resemblance to the claimant whom I have examined.

I hereby certify that the answers above are full, complete and true.

(Signature of Doctor) with official hospital stamp

Name : _____

Specialization : _____

PTR No. : _____

License No: _____

Date : _____

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