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

HEART ATTACK

This report is to be completed by a registered Cardiologist or Physician at the own expense of claimant.

PATIENT DETAILS

Name (Last Name, First Name, M.I.)	Policy No.
Date of Birth (MMDDYYYY)	
Present Occupation	Gender ☐ Male ☐ Female

I. GENERAL DETAILS

a.) Are you the patient's regular medical attendant?	☐ Yes, since when ☐ No
b.) Is the patient a smoker?	☐ Yes, since when ☐ No
c.) When did your patient first consult you for this condition?	
d.) Symptoms presented at that time	
e.) Date of symptoms first appeared	According to patient : _____ In your opinion : _____
f.) Please describe the exact details of your patient's present condition.	
g.) 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 your patient referred to you? If yes, please give name and address of doctor concerned.	
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).	

1220 Acacia Avenue, Madrigal Business Park, Ayala Alabang, Muntinlupa City 1770
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III. DIAGNOSIS DETAILS II

a.) What tests have been done to confirm the diagnosis and results?	
b.) Please give full details of any chest pain(s) prior to the attack.	
c.) Was an ECG performed? If yes, please give the date and details of the ECG changes. Please enclose a copy of the ECG results.	
d.) Were cardiac enzymes measured? If yes, please provide us with the details of cardiac enzymes levels. Please enclose a copy of the test result.	☐ Yes Details: ☐ No
e.) Were Troponin T tests measured? If yes, please provide us with the details of Troponin T level. Please enclose a copy of the test result.	☐ Yes Details: ☐ No
f.) Was the condition classified as acute coronary syndrome?	☐ Yes Details: ☐ No
g.) i. Was a percutaneous procedure performed? ii. If yes, did the percutaneous procedure for coronary artery disease causes a rise in cardiac biomarkers? Please give details.	☐ Yes Details: ☐ No
h.) Have any other investigative tests or procedures been performed? If yes, please give details and enclose a copy of the report(s).	

IV. 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
Hypertension			
Diabetes Mellitus			
Cardiovascular Diseases			
Cancer			
Other illnesses/ Injuries Please specify			

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

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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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