



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

STROKE

This report is to be completed by a registered Neurologist 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 <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.) 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).	

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.



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III. DIAGNOSIS DETAILS II

a.) In your professional opinion, what caused the stroke?																			
b.) Did the patient suffer from any neurological sequelae?	<input type="checkbox"/> Yes, lasted more than 24 hours <input type="checkbox"/> No, lasted more than 6 months <input type="checkbox"/> Yes, lasted more than 3 months <input type="checkbox"/> No neurological sequelae																		
c.) Please give details of any neurological sequelae or residual defects found on patient.																			
d.) Are these neurological sequelae or residual defects likely to be permanent?	<input type="checkbox"/> Yes <input type="checkbox"/> No																		
e.) Was there any infarction of brain tissue, hemorrhage or embolization from an extra- cranial source? If yes, please give details.	<input type="checkbox"/> Yes Details: <input type="checkbox"/> No																		
f.) Was the patient's stroke incident / cerebral symptoms due to any of the following conditions? If yes, please give details	<table border="0"> <tr> <td>i. Transient Ischemic Attacks</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>ii. Any Reversible Ischemic Neurological Deficit</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>iii. Vertebrobasilar Ischemia</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>iv. Migraine</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>v. Trauma or Hypoxia</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>vi. Vascular Disease affecting Eye or Optic nerve or Vestibular Functions</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> </table> <p>Details:</p>	i. Transient Ischemic Attacks	<input type="checkbox"/> Yes	<input type="checkbox"/> No	ii. Any Reversible Ischemic Neurological Deficit	<input type="checkbox"/> Yes	<input type="checkbox"/> No	iii. Vertebrobasilar Ischemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	iv. Migraine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	v. Trauma or Hypoxia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	vi. Vascular Disease affecting Eye or Optic nerve or Vestibular Functions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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g.) Please provide us with the details on the changes seen in a CT scan or MRI. Kindly enclose a copy of the report.																			
h.) Have any other investigative tests and 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			

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V. 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 : _____