



CF06900001

Certificate No.: \_\_\_\_\_

Claim No.: \_\_\_\_\_

**MEDICAL ATTENDANT'S REPORT ON DREAD DISEASE CLAIM**

**(Aorta Surgery / Heart Valve Replacement)**

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

1. a) Name of Patient.	
b) I/C No.	
c) Date of Birth.	Date: (dd/mm/yyyy)
d) Present Occupation. (If more than one, please state all)	
2. a) Please describe the exact details of your patient's present condition.	
b) Date last seen by you.	Date: (dd/mm/yyyy)
3. a) When did your patient first consult you for the condition?	Date: (dd/mm/yyyy)
b) Symptoms presented at first consultation.	
c) Date of symptoms first appeared prior to first consultation.	Date: (dd/mm/yyyy)
4. a) Please give full details of the diagnosis.	
b) Date of diagnosis.	Date: (dd/mm/yyyy)
c) Name and address of doctor who established the diagnosis.	
d) Was your patient informed of the diagnosis? If yes, when and by whom?	<input type="checkbox"/> Yes    Doctor's name : _____ <input type="checkbox"/> No Date : (dd/mm/yyyy)
5. Had your patient suffered any previous episodes of the condition or any other conditions leading to it or relating to it? If yes, please give details.	<input type="checkbox"/> Yes    Details: _____ <input type="checkbox"/> No
6. a) Was your patient referred to you? If yes, please give name and address of doctor concerned.	
b) Name and address of doctor(s) who attended to your patient prior seeing you.	
c) Name and address of doctor(s) concurrently treating your patient with you for the condition.	
d) Was your patient referred to any other doctor(s) by yourself? Please give name and address of the doctor(s).	

7. a) Date of procedure / surgery.	a) Date: (dd/mm/yyyy)
b) Hospital and name of surgeon who performed the procedure / surgery.	b)

**8. Please answer the questions below in respect of the patient's condition.**

**a) Aorta Surgery**

i. Was thoracotomy or laparotomy performed to repair or correct an aorta aneurysm, an obstruction or a dissection of the aorta? If no, what was the surgery / procedure performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No    Surgery / procedure performed:
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ii. Site of the aorta involved.	<input type="checkbox"/> Thoracic <input type="checkbox"/> Thoracic branches <input type="checkbox"/> Abdominal <input type="checkbox"/> Abdominal branches
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**b) Heart Valve Surgery**

i. Was open-heart surgery performed to replace or repair cardiac valves? If no, what was the surgery / procedure performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No    Surgery / procedure performed:
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9. Had any other investigative tests or procedures been performed? If yes, please give details and enclose a copy of the report.	<input type="checkbox"/> Yes    Details: _____ <input type="checkbox"/> No
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**10. Had 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 (dd/mm/yyyy)	Name & address of Doctor(s) consulted	Dates of Consultation (dd/mm/yyyy)
a) Hypertension			
b) Diabetes Mellitus			
c) Cardiovascular Disease			
d) Other Illnesses / Injuries Please specify:			
i.	i.	i.	i.
ii.	ii.	ii.	ii.

11. Please give other information which you feel would be helpful in the assessment of your patient's claim.	
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Signature: _____ Name (in block capitals): _____ Qualification: _____ Contact No.: _____ Date: _____ (dd/mm/yyyy)	Official Stamp: <div style="border: 1px solid black; height: 80px; width: 100%;"></div>
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