



CF09500001

Certificate No.: _____

Claim No.: _____

MEDICAL ATTENDANT'S REPORT ON DREAD DISEASE CLAIM
(Primary Pulmonary Arterial Hypertension / Severe Eisenmenger's Syndrome)

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?	Yes <input type="checkbox"/> Doctor's name : _____ No <input type="checkbox"/> 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.	Yes <input type="checkbox"/> Details: _____ No <input type="checkbox"/>
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. Please answer the questions below in respect of the patient's condition.

a) Primary Pulmonary Arterial Hypertension

i. Was the disease associated with any underlying causes and conditions, or related to any congenital condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>
ii. Please confirm if your patient falls within either Class III or IV of the New York Heart Association Classification of cardiac impairment.	
iii. What was the extent of the Pulmonary Arterial Hypertension?	
a) Was there dyspnoea and fatigue?	Yes <input type="checkbox"/> No <input type="checkbox"/>
b) Was there increase left atrial pressure of at least 20 units or more?	Yes <input type="checkbox"/> No <input type="checkbox"/>
c) Was there pulmonary resistance of at least 3 units above normal?	Yes <input type="checkbox"/> No <input type="checkbox"/>
d) Was there pulmonary artery pressure of at least 40mm Hg?	Yes <input type="checkbox"/> No <input type="checkbox"/>
e) Was there pulmonary wedge pressure of at least 60mm Hg?	Yes <input type="checkbox"/> No <input type="checkbox"/>
f) Was there right ventricular end-diastolic pressure at least 8mm Hg?	Yes <input type="checkbox"/> No <input type="checkbox"/>
g) Was there right ventricular hypertrophy, dilation and signs of right heart failure and decomposition?	Yes <input type="checkbox"/> No <input type="checkbox"/>
iv. Had any other investigative tests or procedures been performed? If yes, please give details and enclose a copy of the report.	Yes <input type="checkbox"/> Details: _____ No <input type="checkbox"/>

b) Severe Eisenmenger's Syndrome

i. Was the patient's condition caused by the occurrence of a reversed or bidirectional shunt as a result of pulmonary hypertension?	Yes <input type="checkbox"/> No <input type="checkbox"/>
ii. Please confirm if patient falls within in class NYHA IV.	Yes <input type="checkbox"/> No <input type="checkbox"/>

11. 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.

12. Please give other information which you feel would be helpful in the assessment of your patient's claim.

Signature: _____

Name (in block capitals): _____

Qualification: _____

Contact No.: _____

Date: _____ (dd/mm/yyyy)

Official Stamp:

