Section IV - Attending Physician Statement (Heart Related Conditions Claims)

(Applicable to Heart Attack / Myocardial Infarction (MI), Surgery to Aorta, Heart Valve Surgery, Other Serious Coronary Artery Disease, Cardiomyopathy, Coronary Artery By-pass Surgery, Primary Pulmonary Arterial Hypertension or Angioplasty and Other Invasive Treatments for Coronary Artery Disease)

Claim No: ________________________ Policy No: ______________________________

The completion of this form is at the expense of the patient.

Section 1: Patient's Information	
Name:	IC No:
Date of Admission:	Date of Discharge:

Patient's Medical Information	
1) Please provide full and exact details of the diagnosis.	2 i) Date of first consultation with you: (DD/MM/YY) ii) Date first diagnosed: (DD/MM/YY) iii) Symptoms presented during first consultation: iv) Date of symptom(s) first appeared: (DD/MM/YY)
3) Was the patient referred by any other doctor or hospital? ☐ Yes ☐ No If yes, please state name of the doctor and hospital.	

4) Has the patient previously suffered from or detected to have hypertension, diabetes, angina, hyperlipidemia, cardiovascular disease, transient ischemic attack, neurological disorders, renal disease, hepatitis B or C, autoimmune disorder or any other significant illnesses?

☐ Yes ☐ No

If yes, please provide the following:

i) Diagnosis:

ii) Date of Diagnosis:

iii) Medication & Treatment:

iv) Name and Address of Clinic/ Hospital:

5) Type of investigations / tests done to confirm the diagnosis:	6) Was the condition caused by any underlying disease? If yes, please specify:

7) Is the diagnosis due to or associated with any of the following?

(i) Congenital anomalies?

(ii) Heredity condition?

(iii) Pregnancy or childbirth?

8) Brief Discharge summary including type of treatment(s), investigations, test, results and/or any complications and follow-up plan.

Section 2 : This section is applicable for heart related conditions.

A. To Be Completed for:

- **Heart Attack / Myocardial Infarction (MI)**
- **Surgery to Aorta**
- **Heart Valve Surgery**
- **Other Serious Coronary Artery Disease**
- **Cardiomyopathy**
- **Coronary Artery By-pass Surgery**
- **Primary Pulmonary Arterial Hypertension**
- **Angioplasty and Other Invasive Treatments for Coronary Artery Disease**

Please tick (/) the box and attach copies of all the relevant laboratory evidences / test below (if any):

- ☐ ECG report
- ☐ All Cardiac Enzymes (CPK-MB, Troponin T/Troponin I)
- ☐ Echocardiogram report
- ☐ Percutaneous Coronary Intervention (PCI) or laser treatment report
- ☐ Other reports. Please give details:
- ☐ Coronary Angiogram report
- ☐ Coronary Artery By-pass Graft Operation report
- ☐ Cardiac catheterization report

1. For heart related condition, please give details of investigations/ test done that confirm the diagnosis.

	Date and time	**Investigation / test results**
Cardiac marker (CK/CPK-MB/Troponin T or I)		
ECG		
Echo/ Others		

2) Please complete the following:

(i) Please specify the coronary arteries involved and the percentage of stenosis.

Coronary Artery	**Stenosis**		**Percentage (%) of stenosis**
	Yes	**No**	
Left main Stem			
Left anterior Descending Artery			
Left Circumflex artery			
Right coronary artery			
If other than above, please specify:			

(ii) Please give details of procedure / surgery performed.

Tick (/)	**Procedure /Surgery performed**	**Date and time surgery**	**Doctor who performed surgery and Hospital Name**
	Coronary Artery By-pass Graft via open Surgery		
	Percutaneous Coronary Intervention (PCI)		
	Others, please specify:		

3) Please complete the questions if the patient has **cardiomyopathy or primary pulmonary hypertension**:

(i) Details of investigations performed to confirm the diagnosis.

(ii) What is the underlying cause of the cardiomyopathy / pulmonary hypertension?

(iii) Since when did the patient have the underlying cause? (DD/MM/YY)

(iv) Is the cardiomyopathy due to alcohol or drug misuse / abuse? ☐ Yes ☐ No
If yes, please provide details:

B. Additional Information - to be completed for Heart Valve surgery OR Surgery to Aorta

1) Type of surgery performed for Heart Valve surgery:

2) Date of surgery: (DD/MM/YY)

3) Name of doctor who performed the surgery, with name of hospital and address:

4) For Heart Valve surgery:

(i) The approach was via:

☐ Open heart surgery ☐ Key-hole procedure

☐ Intra-arterial procedure ☐ Others: ____________________________

(ii) The procedure done was:

☐ Valvotomy / valvuloplasty ☐ Valve repair ☐ Valve replacement

5) For Surgery to Aorta:

(i) The approach was via:

☐ Thoracotomy ☐ Catheter based techniques

☐ Laparotomy ☐ Key-hole procedure

☐ Intra-arterial procedure

(ii) The surgery was performed for:

☐ Aneurysm ☐ Obstruction

☐ Dissection ☐ Coarctation

☐ Others: ________________________________

iii) The surgery was performed at:

☐ Thoracic aorta ☐ Aortic branches: ____________________________

☐ Abdominal aorta

6) If there is any further information which is in your opinion will assist us in assessing the claim, please furnish us such information.

Please enclose copies of ALL the relevant Laboratory evidences/tests for the respective critical illness claim.

a) Heart Attack / Myocardial Infarction (MI)	ECG report, Cardiac Enzymes Assay results (CPK-MB, Troponin T/Troponin I), Echocardiogram report / Coronary Angiogram report
b) Surgery to Aorta	Aorta Surgery Report
c) Heart Valve Surgery	Heart Valve Surgery Report
d) Other Serious Coronary Artery Disease	Coronary Angiogram Report
e) Cardiomyopathy	Echocardiogram report, Cardiac Catheterization report
f) Coronary Artery By-pass Surgery	Coronary Artery By-Pass Surgery Report
g) Angioplasty and other Invasive Treatments for Coronary Artery Disease	Coronary Angiogram report, Percutaneous Coronary Intervention (PCI) or Laser treatment report
h) Primary Pulmonary Arterial Hypertension	All clinical and laboratory investigation results including cardiac catheterization, Echocardiogram report

Declaration

I hereby certify that the facts given above are true to the best knowledge.

Signature and Stamp:	Name of attending physician/specialist:	Date:
Qualification:	Telephone No:	Hospital: