



AVIVA LTD

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DREAD DISEASE CLAIM – PHYSICIAN’S STATEMENT

Please complete all the sections in this report to the best of your knowledge. Any medical report fee will be borne by the claimant. In order for a claim under this policy condition to be considered, either of the following definitions must be satisfied:-

KIDNEY FAILURE

Definition A

End stage renal failure due to chronic irreversible failure of BOTH kidneys to function. This must be evidenced by the Life Assured requiring regular and long term renal dialysis or renal transplantation. The necessity of continuous dialysis treatment must be certified by a nephrologist’s report.

Definition B

Chronic irreversible failure of BOTH kidneys requiring either permanent renal dialysis or kidney transplantation.

Name of Patient	:	_____	Sex: M / F	Age:	_____
NRIC/Passport No.:		_____	Date of Birth :		_____
Company	:	_____	Occupation :		_____

PART A – PATIENT HISTORY

1) Please state over what period do your records extend:

- a) Date of first consultation:
- b) Date of last consultation:
- c) Number of consultations during the above period:
- d) What were the reasons of consultations (with dates)?

2) Are you the patient’s usual doctor? **YES / NO**

- a) If “Yes”, since what date?

- b) If “No” please advise the name of the regular attending doctor and address of clinic/hospital.

- 3) Was the patient referred to you? **YES / NO**
 (a) If “Yes”, please advise (i) date referred, (ii) reason the patient was referred, (iii) name of doctor recommending the referral, and (iv) name and address of clinic / hospital.
- (b) If “No”, how did he / she come to consult at your clinic or hospital (e.g. A&E)?
- 4) Have you referred the patient to any other doctor(s)? **YES / NO** If “Yes”, please state (a) date referred, (b) reasons for referral, (c) name of doctor(s) referred to, and (d) address of clinic/hospital.
- 5) Besides End Stage Renal Failure, does the patient have or ever have had any significant health conditions, medical history or any illness (e.g. diabetes mellitus, hypertension, hyperlipidaemia, etc)? **YES / NO** If “Yes”, please advise:
- | | | | | |
|----|----------------------------|------------------------|--------------------------|------------------|
| a) | <u>Details of Symptoms</u> | <u>Exact Diagnosis</u> | <u>Date of Diagnosis</u> | <u>Treatment</u> |
|----|----------------------------|------------------------|--------------------------|------------------|
- b) Name of the Doctor(s) (and Clinic Address) whom the patient consulted for the condition(s) stated in (a) above
- c) What is your source of the above information?
- 6) Are you aware of any members of the patient’s family having suffered from any cardiovascular, renal disease, hypertension, diabetes mellitus, neurological or musculoskeletal disorder? **YES / NO** If “Yes”, please advise which family members, nature of illness and date of diagnosis.

- 7) Please give details of the patient's habits in relation to past and present **smoking**, including the duration of smoking habits, number of cigarettes smoked per day and source of this information.

- 8) Please give details of the patients' habits in relation to **alcohol consumption**, including the amount of alcohol consumption per day and the source of this information.

PART B - CONSULTATION FOR PRESENT ILLNESS/INJURY(IES)

- 1) Are you aware that the patient suffered from End Stage Renal Failure? **YES / NO**
- 2) a) Date the patient FIRST noticed symptoms of Renal Failure:

b) What symptoms did the patient notice then?

c) Date the patient FIRST consulted a doctor for the symptoms:
- 3) a) Date you first attended to the patient for renal failure and / or symptoms related to it:

b) Details of the symptoms presented when the patient first consulted you:

c) Duration of symptoms:
(i) According to the patient:

(ii) In your opinion:

d) Underlying cause(s) of the symptoms:

e) Exact diagnosis of the condition:

- 4) Date Renal Failure condition was FIRST diagnosed:
- 5) Name of the doctor and address of hospital / clinic who made the FIRST diagnosis of the condition.
- 6) Was the patient informed of the above diagnosis? **YES / NO**
a) If "Yes", date the patient was first informed of the above diagnosis?

b) If "No", why not?
- 7) Please provide full details of the patient's condition resulting in renal failure and the patient's current condition.
- 8) Is there chronic renal failure of the kidney(s)? **YES / NO** If "Yes", which kidney and since when?
- 9) Is there ***irreversible*** failure of ***both*** kidneys to function? **YES / NO**
a) If "Yes", since when?

b) If "No", please provide details, such as which kidney and to what extent is each kidney affected.
- 10) a) Does the condition require the patient to undergo peritoneal dialysis or haemodialysis?
YES / NO If "Yes", please advise:
i) Date of first and last dialysis:

ii) Frequency of dialysis:

b) Does the condition require the patient to undergo renal transplantation? **YES / NO** If "Yes", please advise date renal transplantation was performed / has been scheduled:

c) Please describe treatment prescribed with dates, other than that mentioned in part (a) and (b) above.

11) Has the patient suffered from any complications arising from or related to Renal Failure? **YES / NO** If "Yes", please provide details, including date of diagnosis and treatment prescribed.

12) What is the prognosis?

13) Please describe and elaborate on the nature and severity of the patient's disability and limitation, if any.

14) Is the patient still on follow-up? **YES / NO**

a) If "Yes", please advise date of last and next appointment:

b) If "No", please advise date of discharge:

15) Is the renal failure condition in any way related or in the presence of any Human Immuno-Deficiency virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? **YES / NO** If "Yes", please state date HIV was diagnosed.

16) Are you aware of any other doctors (in Singapore or overseas) whom the patient consulted for the above illness or any other related diseases? **YES / NO** If "Yes", please advise:

Name of Doctor and Name &
Address of Clinic / Hospital

Date of First & Last
Consultation

Reason &
Treatment

17) Had the patient ever been hospitalised before? **YES / NO** If “Yes”, please advise:

<u>Name of hospital</u>	<u>Reason & Treatment</u>	<u>Date of Admission & Discharge</u>
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18) Please state and attach copies of all reports such as specialist or hospital reports and investigation reports (eg biopsy, histopathology, radiology reports, other imaging studies and laboratory evidence, etc).

19) Do you have any other information that may be important for our assessment of the claim? **YES / NO** If “Yes”, please provide details.

Signature of Physician :

Name of Physician :

Designation :

Clinic's Address & Stamp:

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Date :