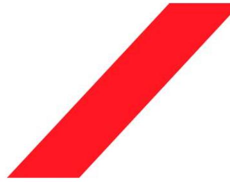
AFFIN



CRITICAL ILLNESS – HEART RELATED CONDITION FORM (BY DOCTOR)

Important Note:
Your patient is insured with us against the happening of certain contingent events associated with his or her health. To enable us to assess the claim, please complete this report with as much details as you can possibly provide. Your kind assistance will help expedite the claim settlement.
(For any medical report fee incurred in completing this form, it will be borne by the claimant)

Policy No

			-							
			-							

1. Patient's details

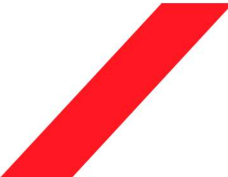
Full Name	
NRIC / OLD IC / Passport No.	
Occupation & exact duties	

2. Medical Record

Are you the patient's regular doctor?	☐ YES ☐ NO	If YES, since when? DD MM YY
Date the patient **FIRST** consulted you for the Illness DD MM YY	Please state the symptom presented during the FIRST consultation	

Symptoms	**Date symptom FIRST presented? (dd/mm/yy)**

Please describe FULL and EXACT diagnosis. ____________________________________ ____________________________________	Date when ILLNESS was FIRST diagnosed DD MM YY
Diagnosis was FIRST made by (Name of Doctor & Hospital) ____________________________________ ____________________________________	Date when patient FIRST became aware of the illness DD MM YY



Which of the following factors are present? Please provide the date of onset

Factors	YES	NO	Date of onset (dd/mm/yy)
Hypertension			
Diabetes Mellitus			
Hyperlipidemia			
Others, please specify :			

What is the source of information :

☐ Patient
☐ Referring doctor. Name of doctor & hospital / clinic : ____
☐ Others, please specify : ____

3. For specific Critical Illness

A. To Be Completed for :
- Heart Attack / Myocardial Infarction (MI), OR
- Coronary Artery By-Pass Surgery, OR
- Other Serious Coronary Artery Disease, OR
- Angioplasty and Other Invasive Treatments for Major Coronary Artery Disease, OR
- Severe Cardiomyopathy, OR
- Primary Pulmonary Arterial Hypertension

Please attach certified true copies of ALL the relevant laboratory evidences / tests available

☐ Electrocardiogram (ECG) tracing
☐ Cardiac Enzymes (CK-MB / Troponin T / Troponin I)
☐ Echocardiogram / Coronary Angiogram Report
☐ Coronary Artery By-Pass Graft Surgery Report
☐ Coronary Angiogram Report
☐ Percutaneous Coronary Intervention (PIC)
☐ Cardiac Catheterization Report
☐ Other reports :

For Heart Attack / Myocardial Infarction :

Investigations / Tests	Date and Time	Investigations / Test Result
Cardiac Marker (CK / CPK-MB/ Trop T or I)		
ECG		
ECHO / Others :		

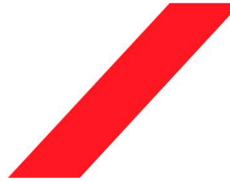
Is there any heart failure / cardiac impairment at present?	☐ Yes ☐ No
Please state the severity of cardiac impairment based on New York Heart Association (NYHA) classification	Class ☐ I ☐ II ☐ III ☐ IV
Is the cardiac impairment likely to be permanent? ☐ Yes ☐ No	Will the cardiac impairment improve? ☐ Yes ☐ No

For Other Serious Coronary Artery Disease

Major Coronary Artery	Blockage		Percentage (%) of blockage
	YES	NO	
Circumflex			
Right Coronary Artery (RCA)			
Left Artery Descending Artery (LAD)			
Left Circumflex Artery (LCA)			
Left Main Stem (LMS)			

Please provide details of procedure / surgery performed

Treatment Type	Treatment	Treatment Date (dd/mm/yy)	Details of Treatment
Open Heart Surgery (Coronary Artery By Pass Graft Surgery)	☐ Yes ☐ No		
Angioplasty (PCI)	☐ Yes ☐ No		
Keyhole Coronary Bypass Surgery	☐ Yes ☐ No		
Others :	☐ Yes ☐ No		



Please provide the below details if the Patient have cardiomyopathy or primary pulmonary hypertension :

Details of investigation performed to confirmed the diagnosis ________________________ ________________________ ________________________	What is the underlying cause of the cardiomyopathy / pulmonary hypertension? ________________________ ________________________
Since when the patient have the underlying cause? ☐☐ DD ☐☐ MM ☐☐ YY	Is the cardiomyopathy due to alcohol or drug misuse / abuse? ☐ Yes ☐ No

To be completed for : - Heart Valve Surgery, OR - Surgery to Aorta, OR	- Percutaneous Heart Valve Surgery

Please attach certified true copies of ALL the relevant laboratory evidences / tests available

- ☐ Heart Valve Surgery Report
- ☐ Aortic Surgery Report
- ☐ Others :
- ☐ Echocardiogram Report
- ☐ Angiogram Report

Type of Surgery	Date of Surgery	Doctor's Name	Hospital Name	Address

For Heart Valve Surgery :

The approach was via :

☐	Open Heart Surgery	☐	Intra-arterial procedure
☐	Key-hole procedure	☐	Others :

The procedure done was :

☐	Valvotomy / Valvuloplasty		
☐	Valve Repair	☐	Valve Replacement

For Surgery to Aorta :

The approach was via :

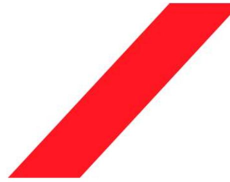
☐	Thoracotomy	☐	Catheter based techniques
☐	Laparotomy	☐	Key Hole Procedures
☐	Intra-arterial procedure		

The surgery was performed for :

☐	Aneurysm	☐	Obstruction
☐	Dissection	☐	Coarctation
☐	Others:		

The surgery was performed at :

☐	Thoracic Aorta	☐	Abdominal Aorta
☐	Aortic branches :		



4. Other Medical Information

Has the patient previously suffered from this illness or any related illness or other illnesses?	☐ Yes ☐ No

If Yes, please provide details as below :

Date of consultation (dd/mm/yyyy)	Illness / Diagnosis	Treatment Received	Investigation Result	Name of Doctor & Hospital

Was the patient referred to you?	☐ Yes ☐ No

If Yes, please provide details below and enclose a copy of the referral letter (if any) :

Doctor's Name	Name of Clinic / Hospital	Address of Clinic / Hospital

5. Declaration & Authorization

I HEREBY CERTIFY that I have personally examined and treated the Patient in connection to the above condition and that the facts as given above present my opinion of his / her condition. I declare and agree to make the declaration of this claim form.

Name :

Address :

Date :

Signature and Official Stamp