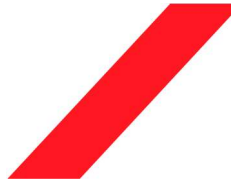




AFFIN



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

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1. Patient's details

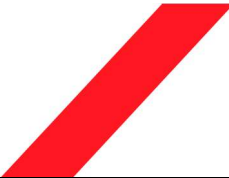
Full Name

NRIC / OLD IC / Passport No.

Occupation & exact duties

2. Medical Record

Are you the patient's regular doctor?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, since when?		
		<input type="text"/> DD	<input type="text"/> MM	<input type="text"/> YY
Date the patient FIRST consulted you for the illness <input type="text"/> DD <input type="text"/> MM <input type="text"/> YY	Please state the symptom presented during the FIRST consultation			
	Symptoms	Date symptom FIRST presented? (dd/mm/yy)		
	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		
Please describe FULL and EXACT diagnosis. _____ _____		Date when ILLNESS was FIRST diagnosed <input type="text"/> DD <input type="text"/> MM <input type="text"/> YY		
Diagnosis was FIRST made by (Name of Doctor & Hospital) _____ _____		Date when patient FIRST became aware of the illness <input type="text"/> DD <input type="text"/> MM <input type="text"/> 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

<input type="checkbox"/> Electrocardiogram (ECG) tracing	<input type="checkbox"/> Coronary Angiogram Report
<input type="checkbox"/> Cardiac Enzymes (CK-MB / Troponin T / Troponin I)	<input type="checkbox"/> Percutaneous Coronary Intervention (PIC)
<input type="checkbox"/> Echocardiogram / Coronary Angiogram Report	<input type="checkbox"/> Cardiac Catheterization Report
<input type="checkbox"/> Coronary Artery By-Pass Graft Surgery Report	<input type="checkbox"/> 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?

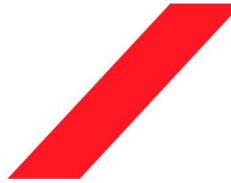
Yes No

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)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Angioplasty (PCI)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Keyhole Coronary Bypass Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Others :	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DD MM YY	Is the cardiomyopathy due to alcohol or drug misuse / abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No

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

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

<input type="checkbox"/> Heart Valve Surgery Report	<input type="checkbox"/> Echocardiogram Report
<input type="checkbox"/> Aortic Surgery Report	<input type="checkbox"/> Angiogram Report
<input type="checkbox"/> Others :	

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

For Heart Valve Surgery :

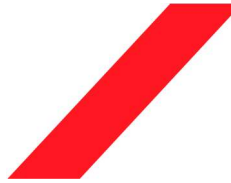
The approach was via :		The procedure done was :	
<input type="checkbox"/> Open Heart Surgery	<input type="checkbox"/> Intra-arterial procedure	<input type="checkbox"/> Valvotomy / Valvuloplasty	
<input type="checkbox"/> Key-hole procedure	<input type="checkbox"/> Others :	<input type="checkbox"/> Valve Repair	<input type="checkbox"/> Valve Replacement

For Surgery to Aorta :

The approach was via :		The surgery was performed for :	
<input type="checkbox"/> Thoracotomy	<input type="checkbox"/> Catheter based techniques	<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Obstruction
<input type="checkbox"/> Laparotomy	<input type="checkbox"/> Key Hole Procedures	<input type="checkbox"/> Dissection	<input type="checkbox"/> Coarctation
<input type="checkbox"/> Intra-arterial procedure		<input type="checkbox"/> Others:	

The surgery was performed at :

<input type="checkbox"/> Thoracic Aorta	<input type="checkbox"/> Abdominal Aorta
<input type="checkbox"/> Aortic branches :	



4. Other Medical Information

Has the patient previously suffered from this illness or any related illness or other illnesses?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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