



Critical Illness Attending Physician's Statement

| | | |
|---|----------------|---------------------------------|
| Patient Information PRINT IN INK | | |
| First Name | Middle Initial | Last Name |
| Address | | |
| Phone Number | Policy Number | Date of Birth DD / MM / YYYY |

ABOUT THE ILLNESS

COMPLETE THIS SECTION FOR ALL CRITICAL ILLNESS CLAIMS AND THE SECTIONS RELATED TO THE SPECIFIC CRITICAL ILLNESS CONDITION

1 Nature of illness or surgery: _____

2 Has the patient ever suffered from this or a similar condition? Yes No

If "Yes," when: DD / MM / YYYY

3 Date symptoms first appeared: DD / MM / YYYY

4 Description of symptoms: _____

5 Date of first consultation for this condition: DD / MM / YYYY

6 Date of diagnosis: DD / MM / YYYY

7 Date patient was informed of diagnosis: DD / MM / YYYY

Name(s) of physician(s) you have referred this patient to or have referred the patient to you:

| NAME | CLINIC OR HOSPITAL |
|------|--------------------|
| | |
| | |
| | |
| | |

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Patient History

8 How long has this person been your patient? _____ **DD / MM / YYYY**

9 Is there a family history of this condition or any other hereditary illnesses? Yes No

If **"Yes,"** please provide details: _____

10 Does the patient use tobacco, nicotine or marijuana products? Yes No

If **"Yes,"** describe the type and daily consumption and how long they have been using them.

 If **"No,"** have they ever used tobacco, nicotine or marijuana products, and if so, when did they stop?

11 Has the patient received care, treatment or services, consulted a physician or been prescribed drugs for any illness or any condition(s)? Yes No

If **"Yes,"** provide details:

| CONDITION | DATE PATIENT WAS INFORMED OF THE CONDITION | RESULTS |
|-----------|--|---------|
| | DD / MM / YYYY | |
| | DD / MM / YYYY | |
| | DD / MM / YYYY | |
| | DD / MM / YYYY | |

Critical Illness Diagnosis

CANCER

Enclose a copy of the complete medical file, including copies of chart notes, consultation reports, investigations, test results and the pathology report for the biopsy which lead to the diagnosis.

Pathological cancer diagnosis: _____

Cancer site: _____

Cancer stage: (I to IV or A to D, as applicable) _____

Is this a recurrence? Yes No

Date of first occurrence: **DD / MM / YYYY**

Date of recurrence: **DD / MM / YYYY**

Is this a cancer in-situ or is there invasion of tissues? _____

Are there lymph nodes involved? Yes No

Is there metastases? Yes No

To where? _____

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HEART ATTACK/MYOCARDIAL INFARCTION

Enclose a copy of the complete medical file, including copies of chart notes, consultation reports, investigations, tests, bloodwork, ECG results, and the hospital discharge summary.

Is this your patient's first myocardial infarction? Yes No

If "No," date of previous infarction: DD / MM / YYYY

Any rises and falls of biochemical cardiac markers to levels considered diagnostic of myocardial infarction? Yes No

Any new electrocardiogram (ECG) changes consistent with a myocardial infarction? Yes No

Any new Q waves during or immediately following an intra-arterial procedure, including an angiography, an angioplasty or other procedure? Yes No

STROKE/CEREBROVASCULAR ACCIDENT

Enclose a copy of the complete medical file, including copies of chart notes, consultation reports, investigations, test results and the hospital discharge summary.

Is this your patient's first cerebrovascular accident? Yes No

If "No," date of previous cerebrovascular accident: DD / MM / YYYY

Have any neurological deficits persisted for more than 30 days after the diagnosis? Yes No

If "Yes," please describe the residual deficits: _____

Was the cerebrovascular accident caused by a trauma? Yes No

If "Yes," please provide details: _____

MULTIPLE SCLEROSIS

Enclose a copy of the complete medical file, including copies of chart notes, consultation reports, investigations, test results and the hospital discharge summary.

Has there been two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination? Yes No

Has there been well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination? Yes No

Has there been a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart? Yes No

Was this diagnosis made by a specialist? Yes No

OTHER ILLNESS

Enclose a copy of the complete medical file, including test results and the hospital discharge summary.

DIAGNOSIS: _____

Description of symptoms, comments or any other information to support this claim:
