

ATTENDING PHYSICIAN'S STATEMENT STROKE

Part 1 (To be completed by the Insured)

Policy No.	Plan Type	Claim No.
Name of Insured (as shown in NRIC)		NRIC No.
Address		
Name of Next-of-Kin (if Insured is below age 21 or deceased)	Relationship to Insured	NRIC No.
Address of Next-of-Kin		
<p>Authorisation I agree and authorise: (a) Any medical institution or medical practitioner, or insurer, or organisation or person to release to NTUC Income any information as requested by NTUC Income; and (b) NTUC Income to release any relevant information concerning me/my child to any medical institution or medical practitioner, or insurer or organisation or person. A photocopy of this form is valid as an original copy.</p>		
_____ Signature/Thumbprint of Insured/Next-of-Kin*		_____ Date (dd/mm/yyyy)

Part 2 (To be completed by Doctor)

Name of Insured (as shown in NRIC)	NRIC No.	
A. GENERAL INFORMATION		
1. Are you the Insured's usual doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Over what period do your records extend?		
Start Date (dd/mm/yyyy) _____ / _____ / _____	End Date (dd/mm/yyyy) _____ / _____ / _____	
2. When did the Insured first consult you for this condition? _____ (dd/mm/yyyy)		
3. When you first saw the Insured, what were the symptoms presented and their duration? Please state date of onset of symptoms.		
Symptoms presented	Duration of symptoms	Date symptoms first occurred (dd/mm/yyyy)
What/Who is the source of this information?		

* Delete where applicable.

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4. Did the Insured consult any other doctors for this illness or its symptoms <u>before</u> he/she consulted you? If "Yes", please provide details.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of doctor	Name and address of Clinic/Hospital	Date(s) of consultation (dd/mm/yyyy)	Diagnosis made
B. DETAILS OF DREAD DISEASE			
5. a) What is the diagnosis? Please provide full details of the diagnosis.			
b) Date of diagnosis (dd/mm/yyyy) _____ / _____ / _____			
c) Please provide the name and address of doctor and clinic/hospital where the diagnosis was first made.			
d) Please provide the date when the Insured was first informed of the diagnosis (dd/mm/yyyy) _____ / _____ / _____			
6. Please describe the initial episode.			
a) Nature of episode			
b) Date of initial episode (dd/mm/yyyy) _____ / _____ / _____			
c) Is the Insured able to return to normal activities? If "Yes", please state when (dd/mm/yyyy) _____ / _____ / _____ If "No", please state the Insured's current physical and mental limitations.			<input type="checkbox"/> Yes <input type="checkbox"/> No
7. a) How long has the neurological damage lasted since the initial episode? Please provide duration in hours / days / weeks.			
b) Please provide a description of the neurological damage.			
c) Is this neurological damage permanent?			<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Is the condition considered a Transient Ischaemic Attack? If "Yes", please provide details.			
9. Is the condition a brain damage due to an accident or injury, infection, vasculitis or inflammatory disease? If "Yes", please provide details.			

10. Is the condition considered a vascular disease affecting the eye or optic nerve? If "Yes", please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
11. Is the condition considered an ischaemic disorder of the vestibular system? If "Yes", please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
12. Please provide details of all investigations/tests performed and enclose copies of all reports, e.g. CT scan and MRI scan reports, other imaging studies, laboratory evidence, and other relevant hospital reports.			
13. Are the investigation findings consistent with the diagnosis of a new Stroke? If "Yes", please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No		
14. Please provide details of all doctors and clinics/hospitals to which the Insured has been referred to or attended for this condition.			
Name of doctor	Name and Address of Clinic/Hospital	Date(s) of consultation (dd/mm/yyyy)	Diagnosis made
C. MEDICAL HISTORY			
15. Has the Insured previously suffered from Stroke or any related illnesses (e.g. hypertension, transient ischaemic attack, angina and other cardiovascular diseases)? If "Yes", please provide details, including date of diagnosis, name and address of doctor/clinic and source of information.			<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Please give details of the Insured's family history which would have increased the risks of having a Stroke (including the relationship, nature of illness, date of diagnosis and source of information.)			
17. Please give details of the Insured'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.			
18. Please give details of the Insured's habits in relation to alcohol consumption, including the amount of alcohol consumption per day and source of this information.			

19. Does the Insured have or ever had any other significant health condition(s)?
 If "Yes", please provide details. Yes No

Diagnosis	Name of doctor	Date of diagnosis (dd/mm/yyyy)	Duration of condition	Treatment received

D. ADDITIONAL INFORMATION

20. Please provide us with any other additional information that will enable us to assess this claim.

Signature of Doctor

Date (dd/mm/yyyy)

Name and Qualification (printed)

Address & Official Stamp of Clinic/Hospital