

CANCER

DOCTOR'S STATEMENT

Kindly answer all questions completely at this will assists us to access the claim accurately, fairly and promptly. We appreciate your co-operation. The cost of this report is borne by the applicant.

Patient's Name :	Patient's I/C Number :	Patient's Passport Number :	Certificate Number :
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A	General Information		
1	Are patient's usual medical doctor ?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	If yes,over what period do your record extend to ?	Date Month Year ____/____/____	
2	When did the patient first consult you for this condition ?	Date Month Year ____/____/____	
3	What were the symptoms and their duration? _____ Please state the date of onset of first occurrence of symptoms.	Date Month Year ____/____/____	
4	In your opinion, what were likely duration of the patient's symptoms?Please provide reasons. _____		
5	Did the patient consult any other doctor for those symptoms before she/he consulted you? If yes,please provide the name of the doctor and clinic/hospital. _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	
B	Details of Critical Illness		
6	Please provide full details of the diagnosis _____ Please state the date of diagnosis	Date Month Year ____/____/____	
7	Please provide the name of doctor and clinic/hospital where the diagnosis was first made. _____		
8	When was the patient first made aware of the diagnosis?	Date Month Year ____/____/____	
9	Which was the site or organ involved? _____		
10	What is the histological of the disease(please provide histology of the tumor)? _____		
11	What is the staging of the tumor? Please provide full details using appropriate staging classification (e.g, TNM Classification, etc) _____		
12	Was there invasion of adjacent tissues?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
13	Were there distant metastases? If yes, please provide full details _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	

B Details of Critical Illness(Continued)	
14	Please provide full details of all treatment provided (e.g. surgery, chemotherapy, etc). _____ _____
15	In the case of a malignant melanoma, please give full details of size, thickness and depth of invasion. _____ _____
16	Please provide details of all investigations performed and enclosed certified true copies, e.g. biopsy reports, cytology and histopathology reports, X-tray, CT and MRI scans, other imaging studies, laboratory evidence, surgical reports and other relevant hospital reports. _____ _____
17	Please provide the names of all doctors and their clinic/hospital which the patients had attend for this condition. _____ _____
C Medical History	
18	Has the patient ever had any malignant, pre-malignant or other related conditions or risk factors? Yes <input type="checkbox"/> No <input type="checkbox"/>
19	Please give details of the patients's family history, which would have increased the risk of Cancer(including relationship to the patient, nature of illness, date of diagnosis and source of information). _____ _____
20	Please give details of the patients'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. _____ _____
21	Please give details of the patients's habits in relation to alcohol consumption, including the amount of alcohol consumption per day and source of this information _____ _____
22	Does the patient have or ever had any other significant health condition? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provided details of the condition, including diagnosis and treatment received. _____ _____
23	Any other information you feel may be relevant. _____ _____

I hereby declare that foregoing answers are true to the best of my knowledge and opinion.

Name: _____

Qualification: _____

Tel. No.: _____ Date: _____

Address: _____

Clinic/Hospital stamp:

Signature: