

KIDNEY FAILURE

DOCTOR'S STATEMENT

Kindly answer all questions completely at this will assist us to access the claim accurately, fairly and promptly. We appreciate your cooperation. 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? _____ _____	Date Month Year ____/____/____	
	Please state the date of onset of first occurrence of symptoms.		
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	What is the diagnosis of the condition resulting in renal failure _____ _____	Date Month Year ____/____/____	
	Please state the date of diagnosis		
7	Please provide the name of doctor and clinic/hospital where the diagnosis was first made. _____ _____		
8	When the patient was first made aware of the diagnosis?	Date Month Year ____/____/____	
9	Is the chronic renal failure of both kidneys?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
10	Is the renal failure reversible?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
11	Has the patient's renal failure reached end-stage? If so, when?	Yes <input type="checkbox"/> No <input type="checkbox"/> Date Month Year ____/____/____	
12	Is the patient currently undergoing permanent renal dialysis? If yes, please state type of dialysis and frequency. _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	
13	Has kidney transplantation been performed? If yes, please give details. If no is surgery planned _____ _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Is the patient on the waiting list of kidney transplant?	Yes <input type="checkbox"/> No <input type="checkbox"/>	

B Details of Critical Illness(Continued)

14 Please provide full details of all investigations/test performed and attach certified true copies of all hospital surgical procedures including cystoscopy report, histological, radiological reports (X-tray, pyelograms, etc.) and other relevant hospital reports. _____

C Medical History

15 Has the patient previously suffered from kidney disease or any related illnesses? Yes No
If yes, please provide details _____

16 Please give details of the patient’s medical history which would have increased the risk of renal disease?

17 Please provide names of the doctor together with the names of the hospital/clinic for which the patient had attend for this condition.

18 Please give details of the patient’s family history which would have increased the risk of renal disease (including relationship, nature of illness, and date of diagnosis and source of information). _____

19 Please give details of the patient’s habits in relation to smoking, including the duration of smoking habits, number of cigarettes smoked per day and source of this information. _____

20 Please give details of the patient’s habits in relation to alcohol consumption, including the amount of alcohol consumption per day and source of this information _____

21 Does the patient have or ever had any other significant health condition? Yes No
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: _____