ATTENDING PHYSICIAN'S STATEMENT

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To be completed by the attending physician at the Insured Person's expense.

Name of Patient		Passport/Identity Card No.	
What is the diagnosis and when was it diagnosed?	D D M M Y Y Y Y ☐ Injury ☐ Sickness		
Was the patient referred to you by a general practitioner?	☐ Yes ☐ No If yes, please indicate his/her name and address.		
Of what symptons did the patient complain? When did patient first consult you for this condition?			
To the best of your knowledge, has the patient ever had the same or similar condition(s) or symtom(s)?	☐ Yes ☐ No If yes, please state dates and conditions / symptoms:		
Was the condition caused by any underlying disease?	☐ Yes ☐ No If yes, please specify:		
According to the patient, how long had he/she been experiencing these symptoms?		How long do you feel the symptoms had lasted?	
Had the patient previously seen any other doctor on account of these symptoms?	☐ Yes ☐ No If yes, please provide name & address of doctor treating the patient.		
Is this a prearranged consultation or admission?	☐ Yes ☐ No If yes, please state the name & address of the referring doctor.		
Did you inform the patient of your diagnosis and has any treatment been recommended?	☐ Yes ☐ No If so, When did you do so? D D M M Y Y Y Y		
Is the diagnosis due to or associated with any of the following?	Congenital anomalies? ☐ Yes ☐ No Drugs or alcohol? ☐ Yes ☐ No Cosmetic or plastic surgery? ☐ Yes ☐ No Mental or nervous disorders? ☐ Yes ☐ No Suicide or attempted suicide? ☐ Yes ☐ No Pregnancy or child birth? ☐ Yes ☐ No	Heredity conditions? ☐ Yes ☐ No Refractive error or correction of eyesights? ☐ Yes ☐ No Routine medical check-up? ☐ Yes ☐ No General health screen? ☐ Yes ☐ No HIV? ☐ Yes ☐ No Self-inflicted injury? ☐ Yes ☐ No	
Did injury or sickness require	Hospitalisation? ☐ Yes ☐ No Date Admitted D D M M Y Y Y Y Date Discharged D D M M Y Y Y Y X-rays? ☐ Yes ☐ No Special diagnostic procedures? ☐ Yes ☐ No Surgery? ☐ Yes ☐ No		
If the patient had a surgical procedure, please fill in the boxes below			
Name and nature of procedure		Date of the operation	D D M M Y Y Y Y
In the case of injury, were the patient's complaints solely caused by this current accident? If not, is there any connection with a pervious accident or any other causes? Please specify.			
Brief discharge summary (including treatments, investigation procedures, results, and /or any complications and follow-up plan)			
Is the patient taking any medication relevant to the above condition? If yes, please specify the medications and when was he first prescribed with it.			

PLPF100-06/13

Is the patient undergoing any test or waiting for result of any test? If yes, please specify the tests.	
Was patient given a terminal diagnosis? If yes, please state the date when patient was notified of his/her terminal diagnosis	☐ Yes ☐ No D D M M Y Y Y Y
Is the patient still under your care for this condition?	☐ Yes ☐ No
Bearing in mind the patient's occupation, do you feel that the injuries or sickness would have prevented him from working?	
How long was, or will the patient be continuously totally disabled (unable to work)	
How long was, or will the patient be partially disabled?	
Give details of any circumstances, such as intoxication, physical defects or medical history which may have contributed to the accident or sickness and/or lengthen the period of disability.	
Whether injuries sustained will result in any permanent disablement/incapacity. If so, please advise extent of disablement/incapacity.	

DECLARATION AND AUTHORISATION

I hereby certify that I have personally examined and treated the patient for the above *injuries/sickness and that the facts as given above represent my opinion of *his/her condition.

Name of Physician		Tel no.	
Address			
Signature		Dated	D D M M Y Y Y Y
Company Stamp		Qualification	

*delete as applicable

NB: No claim can be admitted unless medical certificate from a duly qualified and registered medical practitioner on the form above is furnished at the expense of the Insured,

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