CHUBB®

Lady's Partner Claim
Attending Physician's Statement
(to be completed by attending physician at the claimant's own expenses)

Policy no. |_|_|_|_|_|_|_|_|_|_|_|

Patient's name	HKID Card/Passport no.	Date of birth DD MM YYYY / /	Sex	Age

A. General Information

1. Are you the patient's usual doctor? ☐ Yes ☐ No
   Since when (/ /) DD MM YYYY

2. Was the patient referred to you by other physicians? ☐ Yes ☐ No
   Name of doctor _____ Address _____

3. a. When were you first consulted for this illness?
   (/ /) DD MM YYYY

   b) For how long have these symptoms existed according to this patient?
   Since (/ /) DD MM YYYY OR for _____ year(s) _____ month(s) _____ days(s)

   c) What was the exact diagnosis? When was it made?
   Diagnosis _____ Date of diagnosis (/ /) DD MM YYYY

   d) Was the patient informed of the diagnosis? When and by whom? ☐ Yes ☐ No
   Date inform (/ /) DD MM YYYY Name & address of doctor _____

4. Has the patient previously suffered from the condition specified above or any related illness? ☐ Yes ☐ No
   When (/ /) DD MM YYYY Name & Address of Doctor _____
   Diagnosis _____

5. Do you know any other physician(s) or medical facilities the patient has consulted for this condition ☐ Yes ☐ No

Name of physician / facility	Address	Date of consultation/confinement period
		From (/ /) DD MM YYYY To (/ /) DD MM YYYY
		From (/ /) DD MM YYYY To (/ /) DD MM YYYY

6. Is there anything in the patient's family history which would increase the risk of this illness? ☐ Yes ☐ No
   Details _____

7. Please give details of the patient's habits in relation to alcohol, drugs and smoking (including no. of sticks smoked per day)

B. Extent of Illness

1. If the diagnosis was Systemic Lupus Erythematosus (SLE) with Lupus Nephritis

a). Please confirm which of the following clinical manifestations was exhibited by the patient:

	Yes	No		Yes	No		Yes	No
Malar rash	☐	☐	Arthritis	☐	☐	Lymphopenia (<1,500/μL)	☐	☐
Discoid rash	☐	☐	Serositis	☐	☐	Haemolytic anaemia	☐	☐
Photosensitivity	☐	☐	Renal disorder	☐	☐	Thrombocytopenia (<100,000/μL)	☐	☐
Oral ulcers	☐	☐	Leukopenia (<4,000/μL)	☐	☐	Neurological disorder	☐	☐

Others (please specify) _____

_____

b). Results & dates of following laboratory test (Please provide copy of test results):

	Positive	Negative	Not Tested
Anti-nuclear antibodies	☐	☐	☐
LE cells	☐	☐	☐
Anti-dsDNA	☐	☐	☐
Anti-Sm (Smith IgG autoantibodies)	☐	☐	☐

c). Results of other investigations, e.g. biopsy, renal function tests, creatinine clearance rate, etc.

Date	Type of test	Results
_____	_____	_____
_____	_____	_____

2. If the diagnosis was Pre-cancerous changes

a). of breast(s), uterus, ovary, fallopian tube or vagina

i) Date of diagnosis (/ /) DD MM YYYY

Results of the biopsy (please provide copy of histopathology reports) with date:

_____

ii) When and where did the patient undergo investigation or receive treatment for any abnormality of the breast(s) before diagnosis was made?

Date	Type of investigation/treatment	Name & address of doctor/hospital/laboratory	Results
(/ /) DD MM YYYY	_____	_____	_____
(/ /) DD MM YYYY	_____	_____	_____

b). of cervix uteri,

i) Date & results of the latest and all previous Pap smear tests (please provide copy of cytology reports):

Date	Result of Pap smear tests
(/ /) DD MM YYYY	_____
(/ /) DD MM YYYY	_____

ii). Date & results of the cone biopsy or colposcopy with cervical biopsy (please provide copy of report):

Date	Type of biopsy	Result
(/ /) DD MM YYYY	_____	_____
(/ /) DD MM YYYY	_____	_____

iii) When & where did the patient receive treatment for cervical carcinoma-in-situ or an abnormal smear?

Date	Type of treatment	Name & address of doctor/hospital/laboratory
(/ /) DD MM YYYY	_____	_____
(/ /) DD MM YYYY	_____	_____

3. If related to Major Plastic Surgery due to accidents or Skin Transplantation due to accidental burning,

a). Date and time of accident	Date: (DD / MM / YYYY) Time: (AM / PM) Location:
b). Please state the cause of the accident	

c). Please give details of all consultations and treatments given as far as your records go back:

Date	Complaints & symptoms	Diagnosis	Type of treatment given	Duration of such treatments

d). i) Names and address of hospitals admitted after the accidents	
ii) Period of hospitalization	
iii) Extent and severity of the injury	
iv) What type of plastic surgery was done? (For major plastic surgery)	
v) What percentage of the body surface area did the burning affect as measured by the Lund and Browda Body Surface Chart? (For skin transplantation)	
vi) Why did you think the plastic surgery or skin transplantation was necessary?	
vii) Is further hospitalization/surgery necessary?	
e). What is the present condition and prognosis of the patient?	present condition _____ prognosis _____

4. If the diagnosis was related to Complication of Pregnancy	
a). Disseminated Intravascular Coagulation	
i) What are the precipitating factors	
ii) What was the gestational stage when the condition first appeared?	
iii) Was the condition a result of abortion or its complications?	
iv) How did the condition manifest? What treatment was given?	
v) What other treatment were given?	Dates _____ (DD / MM / YYYY) Results _____
b). Ectopic Pregnancy	
i) What are the precipitating factors?	
ii) Dates of diagnosis and details of all investigations resulting in the diagnosis:	Dates _____ (DD / MM / YYYY) Results _____
iii) Was the Ectopic Pregnancy terminated by Laparotomy or Laparoscopic Surgery?	☐ No ☐ Yes, type of surgery: _____
iv) Please give details of the subsequent management and treatment of the patient.	
v) Has the patient had any previous history of Ectopic Pregnancies?	☐ Yes, Date _____ (DD / MM / YYYY) Name of Physician _____ Consultation dates _____ Results _____

5. If the diagnosis was related to Neonatal Death	
i) Date of birth	(DD / MM / YYYY)
ii) Name of the child	
iii) Name of the mother	
iv) Date of death	(DD / MM / YYYY)
v) Sign & symptom / diagnosis before death	
vi) Cause of death	
6. If the diagnosis was related to Congenital Abnormalities	
a). Down's Syndrome	
i) Please give details of:	
- clinical manifestations	
- diagnostic tools, including dates & results	
ii) Please comment the physical and mental development of the child.	
iii) By whom was the child diagnosed of Down's Syndrome?	Name of doctor
	Address
b). Spina Bifida	
i) Please give details of all investigations conducted as part of the diagnosis (including date & results)	Dates (DD / MM / YYYY) Results
ii) Were there clinical manifestations of meningomyelocele or meningocele?	
iii) Please give details of resultant neurological deficits	
c). Tetralogy of Fallot / Transposition of the Great Vessels	
i) What were the dates and findings of echocardiogram or cardiac catherisation? (Please provide copy of test results)	Dates (DD / MM / YYYY) Results
ii) Please give details of all investigations conducted as part of the diagnosis (Please provide copy of test results)	Dates (DD / MM / YYYY) Results

7. Please state if the patient has suffered / been treated for any other illness(es) / complaints other than this condition.

8. Is there any further information which in your opinion will assist us in assessing this claim?

I hereby certify that I have personally examined and treated the insured in connection to the above condition and that the facts as given above present my opinion of his / her condition. I declare and agree to make the declarations on Part II of this claim form.

Name of physician (with stamp)	Qualification	Signature	Date

Address:

Tel no.:

Chubb. Insured.℠