PRU LIFE U.K.

ATTENDING PHYSICIAN'S STATEMENT - CRISIS COVER (Renal Failure)

Name of the Patient (Last name, First name, Middle name) | **Date of Birth**

The above is insured with us against the happening of certain contingent events associated with his/her health. A claim has been submitted in connection with his/her insurance policy. To enable us to assess the claim, we would be grateful for your cooperation in the completion of this form.

*** Instruction : This form shall be accomplished by each and every Attending Physician who diagnosed the patient of the illness sustained.**

A. General

QUESTIONS	YES NO	PLEASE GIVE DETAILS TO "YES" ANSWER
1. Are you the patients usual Attending Physician? 2. If yes, over what period do your records extend?	☐ ☐	
3. What are the patient's chief complaint and other symptoms present upon consultation?		
4. When were you first consulted for this condition, and at that time, how long had he/she been experiencing these symptoms?		
5. On which date did the patient become aware of the condition?		
6. Has the patient previously suffered from the condition specified above or any possible related illness? If Yes, please give details.	☐ ☐	

7. Do you know of any other medical problem/s the patient had in the past? Please give details below.

Date	Hospital/ Clinic	Physician	Diagnosis	Treatment

8. Please give details of the patient's habits in relation to cigarette smoking or drinking.	
9. Are there any predisposing or contributory factors in relation to present illness? If yes, please specify.	

NAME OF THE PATIENT : _____

Last Name, First Name, Middle Name

B. Medical Details

1. Please provide full and exact details of the diagnosis.	
2. What are the laboratory/ Diagnostic Procedures conducted?	
3. What are the treatment / medications given?	
4. In your opinion, is the illness chronic or acute?	
5. Did the patient undergo Peritoneal dialysis ☐ Hemodialysis ☐ Renal Transplantation ☐	
6. Since when did the insured start undergoing a dialysis?	
7. Please give the name and address of all Consultants, Specialists, Hospitals or Dialysis Centers to which your Patient has been referred or attended for this condition.	
Name	**Address**

C. Other Information

1. If there is any further information, which in your opinion, will assist us in assessing the claim, Please give details.	

DECLARATION
I hereby certify that the answers and information given above are full, complete and true.

AUTHORIZATION
I further authorize your Medical Director or any of his/her authorized representative or other person in your employ, to obtain or secure from me or any clinic, hospital or entity all the medical records of the above-named patient. A photographic copy of this authorization is valid as the original.

_____ Signature Over Printed Name of the Attending Physician

_____ Specialization

_____ Date

Address:
License No.: