

Attending Physician Statement - Stroke

(To be completed by a registered physician at insured's expense)

Name of Patient: _____

Age: _____

H.K.I.D.No. of Patient: _____

Sex: _____

We are given to know that the above named (hereafter called the patient) has been under your care. To properly evaluate the condition of the patient, please kindly furnish us the following information:

About the medical condition.

1. Please state the EXACT diagnosis.

2. When was it made?
_____ (DD/MM/YY)
3. By whom was it made? Please give full name of doctor.

4. Has the patient has a history of Diabetes Mellitus, Migraine, Hypertension, Valvular Heart Disease, Drug/Tobacco Use?
() No, the above named patient has no history of the above said condition.
() Yes, the above named patient has _____ condition. Please also answer the following:
 - i) a) First Date Visit of the above condition was on _____ (DD/MM/YY)
 - b) Doctor/Hospital whom/where the patient sought consultation of the said condition mentioned in Q.3
Dr. Name: _____ Phone No: _____
Clinical/Hospital Address: _____
 - ii) If the condition is Drug/Tobacco Use, please circle one and answer the followings:
 - a) What is the consumption pattern?

 - b) How long did the patient start such pattern?

5. What is the EXACT CAUSE of the stroke?
6. Have the neurological symptoms lasting more than 24 hours? Please expound.

7. Is there any permanent neurological deficit, including but not limited to permanent loss of motor or sensory function, or loss of speech? Please provide details.

8. Has there been an infraction of brain tissue, hemorrhage of an intracranial vessel, embolization from an extra cranial source?
Please provide details.

9. What tests, such as E.G., MRI or CT Scan etc. have been done to confirm the findings?

10. What is the prognosis? According to your professional opinion, does the disorder pose any life threatening signs or does it result in any permanent/irreversible loss of function.

About the medical history

11. When did the first consultation take place for the related signs and symptoms?

_____ (DD/MM/YY)

12. What sign(s) and symptom(s) was/were being aware of at the onset of the disorder?

13. According to the patient, for how long had such symptoms(s) persisted before the first consultation mentioned in Q.11?

14. Please list in below all medical consultations, hospital confinement, surgical procedure and course of medical therapy relating to the said disorder and / or its related symptom(s).

Date/Period	Medical Treatment Type	Details
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

15. Please indicate if the said disorder is associated with

- () Under the influence of drug or alcohol
- () Congenital Nature

16. Please attach copy of pathological/laboratory reports relating to the said disorder.

Signature of Physician with chop

Date

Physician Name in Block

Qualification

Clinical Address and phone number of Physician

Hospital Stamp
