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**ATTENDING PHYSICIAN’S STATEMENT**

(To be accomplished by the Attending Physician)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patient’s Name:** |  | | **Patient’s Last Name:** |  | |
| **Patient’s Date of Birth** (mm/dd/yyyy): | |  | **Patient’s Policy/Application No.:** | |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. When did you first see the patient for consultation? | | | | | |  | | | | | | | | | | |
| 1. What were the presenting symptoms? | | | | |  | | | | | | | | | | | |
| 1. When was the condition diagnosed or when did the patient first experience the symptoms? | | | | | | | | | | | | |  | | | |
| 1. Please describe the symptoms. | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| 1. Are the symptoms becoming: | | | More Frequent | | | | | | | Less Frequent | | | | | Unchanged | |
| 1. When did the patient last experience the symptoms? | | | | | | | |  | | | | | | | | |
| 1. Please enumerate medical tests or investigations for this condition? Please provide details of results. | | | | | | | | | | | | | | | | |
| Name of Test or Investigation | | Date (Month/Year) | | | | | | | | | | Results | | | | |
| Barium Meal | |  | | | | | | | | | |  | | | | |
| Colonoscopy | |  | | | | | | | | | |  | | | | |
| Endoscopy | |  | | | | | | | | | |  | | | | |
| Gastroscopy | |  | | | | | | | | | |  | | | | |
| Ultrasound | |  | | | | | | | | | |  | | | | |
| CT Scan/MRI | |  | | | | | | | | | |  | | | | |
| Biopsy | |  | | | | | | | | | |  | | | | |
| Proctosigmoidoscopy | |  | | | | | | | | | |  | | | | |
| Blood Test | |  | | | | | | | | | |  | | | | |
| Others: | |  | | | | | | | | | |  | | | | |
| 1. Please enumerate medications taken or treatments done on the patient for this condition: | | | | | | | | | | | | | | | | |
| Name of medication or treatment | Dose | | | | | | Frequency | | | | | | | Date Last Taken (Month/Year) | | |
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| 1. What was your complete diagnosis? Please provide details. | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| 1. Was the patient hospitalized or undergone any surgery? | | | | | | | | | Yes (Please provide details.)  No | | | | | | | |
| Name of Hospital | | Date (From/To) | | | | | | | | | Nature of Surgery (If any) | | | | | |
|  | |  | | | | | | | | |  | | | | | |
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|  | |  | | | | | | | | |  | | | | | |
| 1. Has patient’s condition: | Recovered | | | Improved | | | | | | | Unchanged | | | | | Retrogressed |
| 1. Please provide any additional information that you feel is important. | | | | | | | | | | | | | | | | |
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| **DECLARATION** |
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| **I hereby certify that I have personally examined and treated the patient in connection to the above condition and that the facts given above present my opinion of his/her condition. I declare and agree to make the declaration on this form.** |

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| --- | --- | --- |
| **Name of Physician:** | |  |
| **Field of Specialization:** | |  |
| **Mobile No.:** |  | |
| **E-mail Address:** |  | |
| **Clinic Address:** |  | |

|  |  |
| --- | --- |
| **Signature of Attending Physician:** |  |

|  |  |
| --- | --- |
| **Date of Signing** (mm/dd/yyyy)**:** |  |

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