

**ATTENDING PHYSICIAN’S STATEMENT**

(To be accomplished by the Attending Physician)

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

|  |  |
| --- | --- |
| 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) |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| 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) |
|       |       |       |
|       |       |       |
|       |       |       |
| 1. Has patient’s condition:
 | [ ]  Recovered | [ ]  Improved | [ ]  Unchanged | [ ]  Retrogressed |
| 1. Please provide any additional information that you feel is important.
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|       |

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| **DECLARATION** |
|  |
| **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)**:** |       |

