Etiqa Insurance Pte Ltd (Company Reg. No. 201331905K)
23 Church Street, #01-01 Capital Square, Singapore 049481 | T +65 6887 8777 | www.etiqa.com.sg

Attending Physician's Statement

If there is insufficient space on the form to complete a particular question, please continue on a blank sheet of paper.

Name of Patient		NRIC / Passport Number / FIN
Height (cm)	Weight (kg)	Smoker Status

A. Questions

1. Please state the date of first and last consultation dates (dd/mm/yyyy)

1st Consult:	Last Consult:

2. What was / were the reason (s) for the consultation?

3. Does your patient has any of the following complications

- ☐ Diabetes mellitus
- ☐ Stroke / TIA or any stenosis of the arteria carotis
- ☐ Left ventricular thrombus
- ☐ Moderate / Severe COPD
- ☐ Abdominal aortic aneurysm (>3cm) or thoracic aortic aneurysm (>3.5cm)
- ☐ Smoke 40 sticks or more per day
- ☐ Diffuse CAD without possible therapy
- ☐ Symptomatic peripheral occlusive vascular disease
- ☐ Left main stem stenosis > 30%
- ☐ Renal artery or mesenterial artery stenosis
- ☐ Shortness of breath at rest or signs of severe heart failure
- ☐ BMI > 40

4. What were the investigations done? Please provide dates and results. **Please also provide a copy of all investigative reports (past and recent)**

Date of Investigation	Type of Investigation	Details and Results of Investigation

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A. Questions (Continue)

5. Are any of the following ECG findings present? **Please provide a copy of the ECG tracing (past and recent)**

- ☐ Exercise induced ST elevation > 1mm in leads without pathological Q waves and not in lead aVR
- ☐ Early onset of horizontal or down-sloping ST depression (≤ 6 MET or 120 beats/minute)
- ☐ Multiple leads (>5) with significant ST depression
- ☐ Prolonged duration (>5 min) of horizontal or down-sloping ST depression in recovery
- ☐ Chest pain during exercise
- ☐ Exercise induced transient left BBB
- ☐ Exertional hypotension (sustained decrease in systolic blood pressure during progressive exercise below that measured at rest)
- ☐ Abdominal aortic aneurysm (>3cm) or thoracic aortic aneurysm (>3.5cm)

6. Exercise ECG - **Please provide copy of the Exercise ECG result (past and recent)**

a Is a current Exercise ECG available (no more than 2 years from current year)? ☐ Yes ☐ No

b If not available, date of last Exercise ECG done _____

c If it is available, is the result normal? If No, please state findings ☐ Yes ☐ No

_____

_____

d Please state Exercise Capacity _____ **METS**

7. Angiographic Findings – Please provide **all copies of the Coronary Angiogram Report (past and recent)**

a Date when Coronary Artery Disease was first diagnosed (dd/mm/yyyy) _____

b
- ☐ No myocardial infarction
- ☐ One myocardial infarction (indicate date) _____
- ☐ More than one myocardial infarction (indicate dates) _____

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c Date of most recent coronary angiogram done (dd/mm/yyyy) _____

d Most recent angiographic findings

- ☐ Non-obstructive disease
- ☐ Single vessel disease
- ☐ Multiple vessel disease

e Date of most recent echocardiogram (dd/mm/yyyy) _____

f Ejection fraction (EF) % _____

g Persistent chest pain

- ☐ Unknown
- ☐ No persistent chest pain
- ☐ No or slight limitations (CCA I or II)
- ☐ With significant limitations (CCS III or IV)

8. What treatment is administered? Please state

Platelet aggregation inhibitors (e.g. Aspirin / Clopidogrel)	☐ Yes	☐ No
Beta blockers (e.g. Metoprolol)	☐ Yes	☐ No
ACE-inhibitors or AT-II-receptor antagonists (e.g. Ramipril)	☐ Yes	☐ No
Lipid lowering therapy (e.g. Statins)	☐ Yes	☐ No
Thrombolysis at time of infarction	☐ Yes	☐ No
Angioplasty and/or bypass	☐ Yes	☐ No

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A. Questions (Continue)

9. Please describe patient's compliance to treatment and follow-up

_____

_____

10. What is the patient's prognosis?

_____

_____

11. Please provide us with any other additional comments that you feel may assist us to better understand the patient's impairments or health status.

_____

_____

_____

Please enclose a copy of all investigation reports that you have on this patient.

B. For Doctor's Completion

This statement has been completed by

Name of Doctor: _____

Signature: _____

Date: _____

Clinic Stamp: