

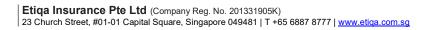
Attending Physician's Statement										
If there is insufficient space on the form to complete a particular question, please continue on a blank sheet of paper.										
Name of Patient				NRIC / Passport Number / FIN						
Нє	eight (cm)	Weight (kg)		Smoker Status						
A	A. Questions									
1.	Please state the date of firs	ease state the date of first and last consultation dates (dd/mm/yyyy)								
	1 st Consult:		Last Cor	Last Consult:						
2.	What was / were the reason	n (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 4. What were the investigations done? Please provide dates an reports (past and recent)		☐ 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 Indeed the results. Please also provide a copy of all investigative							
	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)							

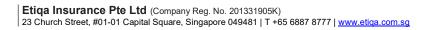
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A.	A. Questions (Continue)							
С	Date of most recent coronary angiogram done (dd/mm/yyyy	/) _						
d	Most recent angiographic findings		☐ Non-obstructive disease☐ Single vessel disease☐ Multiple vessel disease					
е	Date of most recent echocardiogram (dd/mm/yyyy)	_						
f	Ejection fraction (EF) %							
g	Persistent chest pain		Inknown Io persistent chest pain Io or slight limitations (CCA I or II) Vith significant limitations (CCS III or IV)					
8. \	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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Name of Patient	NRIC / Passport Number / FIN						
A. Questions (Continue)							
Please describe patient's compliance to treatment and follow-up							
10. What is the patient's prognosis?							
10. What is the patient's prognosis?							
11. Please provide us with any other additional comments that you f	eel 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							
	Clinic Stamp:						
Name of Doctor:	-						
Signature:	_						
Date:	_						

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