4.3 DREAD DISEASE QUESTIONNAIRE - HEART ATTACK

DREAD DISEASES
QUESTIONNAIRE FOR HEART ATTACK (To be completed by the attending doctor)

PATIENT'S DETAILS:
Patient's name ……..……..

D.O.B. ……. I.D. No. ……..

Address …… Occupation ……..

DETAILS FOR THE INCIDENT

Date of the Heart attack: ……../……../……

Dates of Treatment: From ……/……/…….. To ……/……/……..

Did the patient have an irrevocable reduction of the heart muscle systolic function? YES / NO

Did the patient have medical history of typical angina pectoris pain? YES / NO Date ……/……/……

Are there any electrocardiographically lesions indicants of an acute heart attack? YES / NO

If YES give the dates and type of examinations below:
……

Is there any increase of the cardiac enzymes?

Enzymes	YES / NO	Examination Dates	Outcome
Trobonin			
CPK / CK (MB)			
LDH			
Other			

Is this the first time that the patient had a heart attack? YES / NO
If NO, give details: ……..……
……
Since when do you continuously examine this patient? ……/……./……Date of last examination: ……../…./……
Is the patient under attendance and/or treatment by any other doctor? Give details
……..

	Value	Details / Outcomes
Smoking (daily use)		
Cholesterol		
HDL / LDL		
Triglycerides		
Hypertension		
Family Medical History		

Does the patient suffers or suffered in the past by any disease or illness or syndrome? Give Details:
……..
……..
……

Name of Doctor …… Specialty……
Address……Telephone…….. Fax ……

…….. ……
Doctor's Signature and Seal Date

For supplementary details please use additional blank page

Warning: All supporting documentation (originals) must be provided along with the claim forms

Supporting Documentation for dread disease claim

1. Claim Forms (Fully completed) (Within 6 months from the date of the Diagnosis)
2. Medical Expert's Advice
3. Hospital's/ Clinic's advice if insured has been hospitalized
4. Laboratory tests or any other diagnostic examinations done, together with their outcomes
5. Medical history
6. Photocopy of the Medical booklet (If applicable)