Attending Physician Certificate - Cancer Shield

(Questionnaire to be completed by the specialist who treated the life insured for illness)

1. Personal details of the Patient Life Assured:

Policy Number: ☐☐☐☐☐☐☐☐☐☐ EIA Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Name of Policyholder: _____

Name of Life Insured: _____

Address of the Life insured: _____

_____

Age: ☐☐ Date of Birth: D D M M Y Y Y Y

2. Details of Hospitalization / Treatment:

Name of the hospital: _____

Address of the hospital: _____

_____

Name of Referring doctor: _____

Address of Referring doctor: _____

_____

Telephone No.: ☐☐☐☐☐☐☐☐☐☐ Mobile No.: ☐☐☐☐☐☐☐☐☐☐

Email id: _____

Date of Admission: D D M M Y Y Y Y Date of Discharge: D D M M Y Y Y Y

Details of the Treatment given: _____

3. History reported at the time of admission/consultation: (has to be filled by attending physician)

Details of illness/ Symptoms	
Duration of the above	
Date of First Diagnosis (in case of a known illness/follow up case)	
Any past Medical history of Life insured	
Family History	
Etiology / Cause of the illness	
Present condition of patient	

Name & telephone no. of the Doctor/ Hospital who first diagnosed/treated the patient		
Any surgeries done prior on in course of treatment of the illness	Name of Surgery	Date of Surgery
	1.	
	2.	

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Name of Hospital where surgery was performed	
Name of Hospital where surgery was performed	
History was given by: Life Assured / Family / others. If others: Name: _____ Relationship with the Life Assured: _____	

4. Was the patient admitted or treated or hospitalized earlier? If yes, please provide the following details.

Date of Admission	Date of Discharge	Reason for seeking treatment	Details of the Treatment given

5) Details of diagnosis (has to be filled by attending physician)

Particulars	Description	Date if applicable
Provisional diagnosis		
Tests done and results of the same for confirming the diagnosis		
Final diagnosis		
Type of cancer & site / organ involved		
Histological type and stage/grade of tumor (specify as per TNM classification)		
Disease phase	☐ Primary disease ☐ Relapse	
Is the condition	☐ Benign ☐ Malignant	
a) Is tumor completely localized to the tissue or organ of origin?	☐ Yes ☐ No	
b) Is there invasion of adjacent tissues?	☐ Yes ☐ No	
	If yes, please state which tissues?	
c) Is there involvement of regional lymph nodes?	☐ Yes ☐ No	
	If yes, please state site(s) and number of nodes involved _____	
d) Are there distant metastases?	☐ Yes ☐ No If yes, please state which tissues? _____	
Treatment given	☐ Chemotherapy ☐ Radiation therapy ☐ Surgery ☐ Hormonal therapy ☐ Any others:	
Duration of treatment		
Date of discharge		
If discharge, then condition at discharge & advice given for follow up		

Name of the Doctor: _____

Registration no of the Doctor: _____

Address: _____

_____

Telephone No.: | | | | | | | | | | | Mobile No.: | | | | | | | | | | |

Email id: _____

Declaration

I/We hereby certify that the above information is true and correct as per the records maintained by me/hospitals. I hereby provide my consent to receive call from Aditya Birla Sun Life Insurance Company Limited (ABSLI) or its authorized Service Providers in connection with any matter related to this Policy. Any confidential information, which in your opinion should be in the possession of the company, should be forwarded to Head Office at the below mentioned address

_____

Signature & Seal

Place: _____

Date: | D | D | M | M | Y | Y | Y | Y |