

Attending Physician's Statement (Hospital Income Benefit)



Please PRINT clearly.
If with erasures,
please countersign.

In this form, "you" and "your" refer to the policyowner, life insured, patient and the physician whose information we are processing or disclosing. *We, us, our* and *the Company* refer to Sun Life of Canada (Philippines), Inc., a member of the Sun Life Financial group of companies.

The patient is responsible for the completion of this form without expense to Sun Life of Canada (Philippines), Inc.

1 General Information (to be completed by the patient)

I. Relating to the Life Insured/Patient

Policy Number/s		
Name (Last, First, M.I.)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth(month/day/year)
Residence Address		
Contact Number/s	E-mail Address	
Policyowner (Last name, First name, M.I.) (Please complete if policyowner is other than the life insured)		

Authorization By signing below, you allow us to process and disclose your personal and sensitive personal information to third parties so that we can better help you meet your lifetime needs. If you need more information about our privacy policy, please visit https://apps.sunlife.com.ph/privacy .	Signature of Patient (or Parent, if minor)	Printed Name of Patient/Parent
		Date of Signing (month/day/year)

2 Physician's Statement (to be completed by the Attending Physician)

I. History

a. History of illness and concurrent conditions requiring hospitalization.	
b. Was such hospital confinement necessary to the treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please explain why not.	
c. Was patient given the option to be admitted? <input type="checkbox"/> Yes <input type="checkbox"/> No	d. If hospital confinement was not necessary, did patient insist on being admitted? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", who recommended that the patient be hospitalized?
e. Date patient first consulted you for this condition or symptoms (month/day/year)	f. When did symptoms of present illness first appear? (month/day/year)
g. Has patient ever had same or similar condition? Describe condition. <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", state when. (month/day/year)	
h. Any other illness or impairments to your knowledge? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", what are these?	
i. If hospitalization was due to an accident, when did the accident happen? (month/day/year) How did it happen?	



2 Physician's Statement (to be completed by the Attending Physician) - continued

j. Smoking Habits Question

Does the patient smoke cigarettes/cigarillos/cigars or consume any other tobacco product? <input type="checkbox"/> Yes <input type="checkbox"/> No			
a) If "Yes", fill out appropriate box with quantity per day			
cigarettes	E-cigarettes	cigars	others
b) If "No", has the patient ever smoked a cigarette/cigarillo/cigar or consumed any other tobacco product in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes", when was the last time he/she smoked a cigarette/cigarillo/cigar or consumed any other tobacco product?			
<input style="width: 150px; height: 20px;" type="text"/> month/year			

k. Names and addresses of other attending physicians.

Name and address of Physician

II. Diagnosis

a. Provide full and exact details of the diagnosis.	
b. Nature of Treatment (including surgery, medications prescribed, if any).	
c. For this type of illness or injury, what is the usual expected number of days of hospital confinement? <input style="width: 150px; height: 20px;" type="text"/>	If "Yes", give reason for prolonged confinement.
Was period of hospital confinement longer than necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No	

III. Additional Information

a. Have you received other requests for completion of forms similar to this one for this condition or accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details.	
b. Are you the patient's regular physician? <input type="checkbox"/> Yes <input type="checkbox"/> No How long have you known the patient? If so, how?	Are you related to the patient by blood or by affinity? <input type="checkbox"/> Yes <input type="checkbox"/> No
c. Have you attended to the patient for any other illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", for what illness or injury?	When did you attend to this patient? (month/day/year)

IV. Dates of Hospital Confinement:

Date of Admission (month/day/year)	Date of Discharge (month/day/year)
Name and Address of Hospital	Telephone Number(s)

During the time the patient was hospitalized, was the patient also confined in the Intensive Care Unit? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please state inclusive dates of I.C.U. confinement. From (month/day/year) to (month/day/year)
--

2 Physician's Statement (to be completed by the Attending Physician) - continued

V. Remarks: Please provide comments and further details which you feel would be helpful.

--

3 Signatures

Signature of Attending Physician X		Printed Name of Attending Physician	
License No.	PTR No.	Field of Specialization	
Medical Office Address			
Contact Number/s		E-mail Address	
Clinic Hours	Date of Signing (month/day/year)	Place of Signing	