SuryaJyoti Life Insurance Company Limited
Head Office - Shanta Plaza, Gyaneshwor, Kathmandu Nepal
Tel 4545947/48/50, P.O. Box No. 19433, Email: info@suryajyoti.com

ATTENDING PHYSICIAN QUESTIONNAIRE FOR CRITICAL ILLNESS DIAGNOSIS "STROKE"

(This form is to be completed by attending Neurologist or Specialist Medical Practitioner)

All questions should be answered. If any question is not relevant, please specify as N/A. Any correction should be countersigned and please do not use tippex)

Name of Patient: ……

Date of Birth/Age: ……

Gender: ……

Citizenship Number: ……

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1. Is patient's diagnosis is any of below condition? (Please tick on correct option)

   a. Major Stroke
   b. Transient ischemic attacks (TIA)
   c. Cerebral symptoms due to migraine
   d. Traumatic injury to brain tissue or blood vessels
   e. Vascular disease affecting the eye or optic nerve or vestibular functions

2. If the patient is diagnosed of Stroke, does below conditions meets?

"Death of brain tissue due to inadequate blood supply, bleeding within the skull or embolization from an extra Cranial source resulting in permanent neurological deficit with persisting clinical symptom"

"Permanent neurological deficit with persisting clinical symptoms" means symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the lifetime of the Life Assured. Symptoms that are covered include numbness, paralysis, localized weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

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3. Is the diagnosis based on changes seen in a CT scan or MRI?

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4. Please specify the exact date of patient diagnosed of Stroke as defined above? ……

5. TREATMENT:

Date of first visit …….. Date of last visit …….. Total number of visit ……..

DESCRIBE PRESENT CONDITION Indicate if recovered, improved, unimproved or retrogressed:

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6. Was patient had symptoms for such disease in the past? If Yes, Please Specify types and dates:

……..

7. Is there any other past medical history? If Yes, Please Specify:

……..

8. Was the patient under any kind of Medication in the Past? If Yes, Please Specify types and dates:

……..

9. Is there any indication that patient had been Smoking or any abuse of alcohol or drugs in the past?

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10. For what period was the patient?

Hospital confined (if any)	From ……..	To ……..
House confined (if any)	From ……..	To ……..
Bed confined (if any)	From ……..	To ……..
Ambulatory (if any)	From ……..	To ……..

DECLARATION:

I HEREBY CERTIFY THAT MY ANSWER TO THE FOREGOING QUESTIONS ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF:

Signature: ……

Doctor's Name: ……

Specialization: ……

NMC No: ……

Date: ……

Address: ……

Mobile No.: ……