

CI-01

MEDICAL REPORT TO BE COMPLETED BY THE ATTENDING PHYSICIAN/ SPECIALIST

New NRIC No.

[illegible]

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|---|--|--|
| 1 | <p>Diagnosis</p> <p>(i) Please describe the full and exact diagnosis.</p> <p>(ii) Date when the Cancer was FIRST diagnosed</p> | <p>(i) _____</p> <p>(ii) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy)</p> |
| 2 | <p>For recurrence cancer, please complete below:</p> <p>(i) Date when recurrence cancer was diagnosed:</p> <p>(ii) Details of diagnosis:</p> <p>(a) Has patient completed treatment and declared as cancer-free previously?</p> <p>(b) If Yes, please state the date when cancer treatment was completed:</p> <p>(c) Date MRI/ CT done that confirmed complete cancer remission:</p> | <p>(i) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy)</p> <p>(ii) (a) ☐ Yes ☐ No</p> <p>(ii) (b) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy)</p> <p>(ii) (c) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy)</p> |
| 3 | <p>(i) What was the site or organ involve?</p> <p>(ii) What was the precise histology of the tumour?</p> <p>(iii) What was the stage of the tumour?
Please provide full details using appropriate staging classification (e.g. TNM, Ann Arbor, Duke's etc.)</p> <p>(iv) It is classified as:</p> <p>(v) The disease was:
You may tick (✓) more than one.</p> | <p>(i) _____</p> <p>(ii) _____</p> <p>(iii) _____</p> <p>(iv) ☐ borderline malignancy ☐ non-invasive
 ☐ pre-malignant ☐ invasive
 ☐ carcinoma in-situ</p> <p>(v) ☐ invasive to adjacent tissues ☐ completely localized
 ☐ involved regional lymph nodes
 ☐ distant metastatic. If so, please give details
 _____</p> |

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4 Is the Cancer associated with HIV or AIDS?

☐ Yes ☐ No

If "Yes", please state the date HIV was first diagnosed / detected.

/ / (dd/mm/yyyy)

DECLARATION: TO BE COMPLETED BY THE ATTENDING PHYSICIAN/ SPECIALIST

I, the undersigned, certify that I have examined the above Person Covered and all statement made and answers given are true and to the best of my knowledge and belief.



Signature and Official Stamp

Name: _____

Address:

Date: / / (dd/mm/yyyy)