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| <b>Coronary Artery Bypass Surgery</b>                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 1. Date and time of surgery<br><br>2. The approach was via                                                                                                                                                                                                                                                                             | 1. <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy) _____ a.m. / p.m.<br><br>2. <input type="checkbox"/> Open-chest surgery<br><input type="checkbox"/> Other than open-chest surgery<br>(i.e. intra-arterial procedure, catheter based techniques, keyhole procedure, laser procedure)                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Angioplasty and Other Invasive Treatments for Coronary Artery Disease</b>                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 1. Date and time of procedure was performed                                                                                                                                                                                                                                                                                            | 1. <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy) _____ a.m. / p.m.<br><br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Coronary Artery Balloon Angioplasty<br/><br/> <input type="checkbox"/> Artherectomy<br/><br/> <input type="checkbox"/> Laser treatment         </div> <div> <input type="checkbox"/> Angioplasty and stent placement to correct a narrowing or blockage<br/><br/> <input type="checkbox"/> Intra-arterial investigative procedures<br/><br/> <input type="checkbox"/> Others, ie _____         </div> </div>                                                                                                                                  |
| <b>Primary Pulmonary Arterial Hypertension - of Specified severity</b>                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 1. Cause of pulmonary hypertension<br><br>2. Is there any evidence of right ventricular failure<br><br>(i) Please state the severity of cardiac impairment based on New York Heart Association (NYHA) classification?<br><br>(ii) Is the cardiac impairment likely to be permanent?<br><br>(iii) Will the cardiac impairment improved? | 1. <input type="checkbox"/> without a known case<br><input type="checkbox"/> result of other disease, ie _____<br><br>2. <input type="checkbox"/> Yes <input type="checkbox"/> No<br><br>(i) Class <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV<br>Please provide details of current limitations<br>_____<br><br>(ii) <input type="checkbox"/> Yes <input type="checkbox"/> No<br><br>(iii) <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                               |
| <b>Heart Valve Surgery</b>                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 1. Date and time of surgery<br><br>2. (i) The approach was via<br><br><br>(ii) The procedure done was:                                                                                                                                                                                                                                 | 1. <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy) _____ a.m. / p.m.<br><br>(i) <input type="checkbox"/> Open heart surgery<br><input type="checkbox"/> Intra arterial procedure<br><input type="checkbox"/> Key-hole surgery<br><input type="checkbox"/> Others: _____<br><br>(ii) <input type="checkbox"/> Valvotomy / Valvuloplasty <input type="checkbox"/> Valve repair <input type="checkbox"/> Valve replacement                                                                                                                                                                                                                                                                                               |
| <b>Surgery to Aorta</b>                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 1. Date and time of surgery<br>2. For Surgery to aorta:<br>(i) The approach was via:<br><br>(ii) The surgery was performed for:<br><br>(iii) The surgery was performed at:                                                                                                                                                             | 1. <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy) _____ a.m. / p.m.<br><br>(i) <input type="checkbox"/> Thoracotomy <input type="checkbox"/> Catheter based techniques<br><input type="checkbox"/> Laparotomy <input type="checkbox"/> Key-hole procedure<br><input type="checkbox"/> Intra-arterial procedure <input type="checkbox"/> Laser procedure<br><br>(ii) <input type="checkbox"/> Aneurysm <input type="checkbox"/> Obstruction<br><input type="checkbox"/> Dissection <input type="checkbox"/> Coarctation<br><input type="checkbox"/> Others: _____<br><br>(iii) <input type="checkbox"/> Thoracic aorta<br><input type="checkbox"/> Abdominal aorta<br><input type="checkbox"/> Aortic branches: _____ |
| <b>DECLARATION: TO BE COMPLETED BY THE ATTENDING PHYSICIAN/ SPECIALIST</b>                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 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.                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <div style="border: 1px solid black; height: 100px; width: 100%;"></div> Signature and Official Stamp                                                                                                                                                                                                                                  | Name: _____<br><br>Address: _____<br><br>Date: <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |