ส่วนที่ 3 รายละเอียดความเจ็บป่วยของผู้เอาประกันที่เรียกร้องค่าชดเชยโรคร้ายแรง

Part III Details of Insured's Illness

ECIR-34	NECROTIZING FASCIITIS OR GANGRENE

1. Please describe the extent of the Necrotizing Fasciitis or Gangrene.

i. Date of onset _____ (MM/DD/YY)

	YES	NO
ii. The diagnosis criteria of Necrotizing Fasciitis are met.	☐	☐
iii. Is there widespread destruction of muscle and other soft tissues that result in a total and permanent loss of function of the affected body part?	☐	☐
iv. Did bacteria cause the Nacrotizing Fasciitis?	☐	☐

If 'YES', please give the name of bacteria.

_____

2. What is the nature of treatment?

_____

_____

_____

3. What is the current condition of the insured and what is the prognosis?

_____

_____

_____

4. Investigations/Laboratory report

	YES	NO
i. Was the HIV test performed?	☐	☐

If 'YES', please give result. _____ (MM/DD/YY)

ii. Please enclose copies of all reports that are available.

- ☐ HIV test
- ☐ Hemoculture
- ☐ Gram stain
- ☐ Skin and wound culture
- ☐ Soft tissue radiological studies
- ☐ CT scans / MRI
- ☐ Any other imaging studies
- ☐ Any relevant laboratory evidence
- ☐ Any relevant hospital reports

5. Please state if the insured has suffered/been treated for any other illness (es)/complaints other than the Critical Illness.

_____

_____

_____

6. If there any further information which in your opinion will assist us in assessing this claim, please furnish such information below.

_____

_____

_____

Details of "YES" answers. (Include diagnosis, dates, duration and names and addresses of all attending physicians and medical facilities)

To be completed by Attending Physician

I hereby certify that I have personally examined and treated the insured in connection with the above disability and that the facts are in my opinion as given above.

Name of Doctor _____ Signature _____

Qualification _____ Specialty _____ Thailand's Medical registration _____

Name of Hospital/Official Stamp _____ Telephone No. _____ Date _____