ส่วนที่ 3 รายละเอียดความเจ็บป่วยของผู้เอาประกันที่เรียกร้องค่าชดเชยโรคร้ายแรง

Part III Details of Insured's Illness

ECIR-4 CIR-5	PULMONARY HYPERTENSION

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

1. What was the extent of the Pulmonary Hypertension.

		YES	NO
i.	Was there dyspnea and fatigue?	☐	☐
ii.	Was there increase left atrial pressure of at least 20 units or more?	☐	☐
iii.	Was there pulmonary resistance of at least 3 units above normal?	☐	☐
iv.	Was there pulmonary artery pressure of at least 40 mmHg?	☐	☐
v.	Was pulmonary wedge pressure of at least 6 mmHg?	☐	☐
vi.	Was there right ventricular end-diastolic pressure of at least 8 mmHg?	☐	☐
vii.	Were there right ventricular hypertrophy, dilatation and sign of right heart failure and decompensation?	☐	☐

viii. What was the patient functional class according to New York Heart Association of cardiac impairment? ______________________

2. In your medical opinion, what was the cause of the pulmonary arterial hypertension?

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3. Investigations/Laboratory report

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

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

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

- ☐ HIV test
- ☐ X-rays
- ☐ Resting ECGs
- ☐ Echocardiogram / Ultrasound
- ☐ Cardiac Catheterization
- ☐ Pulmonary function studies
- ☐ Lung scan
- ☐ Any relevant laboratory evidence
- ☐ Any relevant hospital reports

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

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

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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 ______________