บริษัท ไทยสมุทรประกันชีวิต จำกัด (มหาชน)
OCEAN LIFE INSURANCE PUBLIC COMPANY LIMITED
สำนักงานใหญ่ 170/74-83 อาคารโอเชี่ยนทาวเวอร์ 1 ถนนรัชดาภิเษก เขตคลองเตย กรุงเทพฯ 10110
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ใบรับรองความเห็นแพทย์

ภาวะแทรกซ้อนจากโรคเบาหวาน (ทำเลเซอร์จอประสาทตา)

ผู้ป่วย : นาย/นาง/นางสาว/อื่นๆ _____ชื่อ_____ นามสกุล _____ HN: _____

หมายเลขบัตรประชาชน : ☐ ☐☐☐☐ ☐☐☐☐☐ ☐☐ ☐ อายุ _____ปี AN: _____

Details of Insured's illness

1. Date first saw the patient for this illness_____ Present illness _____
2. Chief complaint/Clinical finding (Symptom & signs) _____
3. Diagnosis illness_____ What was the date of complication of Diabetes Mellitus? (DD/MM/YY)_____
4. Please describe the extent of the disease.
   - 4.1 What were signs and symptoms that appeared in first time of diabete mellitus?: _____
   - 4.2 How long the symptoms of diabete mellitus had been present?: _____
   - 4.3 When was the date diagnosed of diabete mellitus?: _____ At hospital_____
   - 4.4 When the patient consulted for this illness in first time?: _____ At hospital_____
   - 4.5 What was the type of diabete mellitus?: ☐Primary DM (Type I) ☐Secondary DM (Type II) ☐Other_____
   - 4.6 Has the patient previously suffered from this illness or any related condition?: ( ) No ( ) Yes
5. Diabetic retinopathy
   - 5.1 Type of neuropathy: ☐ Sensory neuropathy ☐ Motor neurophaty ☐ Autonomic neurophaty
   - 5.2 What are the visual acuity of both eyes at present?: _____
   - 5.3 What are the visual field of the both eyes at present?: _____
   - 5.4 What forms of treatment were rendered?: _____
   - 5.5 Was the loss of sight?: ☐ Left eye ☐ Permanent ☐ Temporary
     ☐ Right eye ☐ Permanent ☐ Temporary
   - 5.6 Will further surgery improve his/her sight? If "Yes", what kind of surgery will be nessessary _____
   - 5.7 Please select the stage of the patient suffered/ complication of diabete mellitus.
     ☐ Diabetic retinopathy ☐ Cerebrovascular neuropathy ☐ Peripheral artery disease ☐ Coronary artery disease
     ☐ Diabetes nephopathy ☐ Other_____
   - 5.8 Treatment of diabetic retinopathy: 5.8.1 LASER treatment ☐ Right eye ☐ Left eye ☐ Both eyes
     5.8.2 Other traetment, please describe _____
6. Investigation/ Laboratory report
   - 6.1 Fasting blood sugar (FBS)_____mg/dl DD/MM/YY report_____ 6.2 HbA1c_____ % DD/MM/YY report_____
   - 6.3 Anti-HIV test: ( ) No ( ) Yes if "Yes" please give result_____ DD/MM/YY_____
   - 6.4 Please enclose copies of all reports that are available:
     ☐ FBS ☐ HbA1c ☐ HIV test ☐ X-ray ☐ Ultrasound ☐ CT scan ☐ MRI ☐ Slit lamp biomicroscope test
     ☐ Indirect ophthalmoscope test ☐ Optical coherence tomography test ☐ Surgery ☐ Any relevant reports_____
7. What is the nature of treatment of DM?:
   ☐ Nutrition control ☐ Exercise ☐ Monitoring ☐ Pharmacologic ☐ On insulin ☐ Other_____
8. Prognosis: ( ) Excellent ( ) Good ( ) Fair ( ) Poor Need follow up_____
9. Could the illness be recover?: ( ) No ( ) Yes for_____ Hours/ Days/ Mouths/ Years
10. Please state if the insured has suffered/been treated for any other illness (es) /complaints other than the Critical Illness.
    _____
11. If there are any further information which in your opinion will assist us in assessing this claim, for example, an adverse family history, please furnish such information_____