



**Critical Illness Claim - Doctor's Statement
Adrenalectomy for Adrenal Adenoma
Special Benefit – Chronic Adrenal Insufficiency (Addison's Disease) / Pheochromocytoma**

DOCTOR'S STATEMENT (to be completed by the attending doctor at claimant's expense)

Please tick (v) the appropriate box for medical condition(s) applicable	Sections to be completed
<input type="checkbox"/> Adrenalectomy for Adrenal Adenoma	Sections A, B, C, D, G and H
<input type="checkbox"/> Chronic Adrenal Insufficiency (Addison's Disease)	Sections A, B, C, E, G and H
<input type="checkbox"/> Pheochromocytoma	Sections A, B, C, F, G and H

A) Patient's Particulars

Name of Patient	Gender										
NRIC/FIN or Passport No.	Date of Birth (ddmmyyyy)										
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B) Patient's Medical Records

1) Please indicate the period that is documented in the hospital/clinic's record:

(i) Date of **First** Consultation (ddmmyyyy):

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(ii) Date of **Last** Consultation (ddmmyyyy):

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(iii) Number of consultations during the above period:

(iv) Name of hospital/clinic and reason(s) for consultations (with dates):

2) Are you the patient's usual medical doctor? Yes No

If "Yes", since when? (ddmmyyyy):

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If "No", please provide name and address of the patient's regular doctor:

3) Was the patient referred to you? Yes No

If "Yes", please provide:

(i) Date referred (ddmmyyyy):

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(ii) Reason for referral:

(iii) Name and address of referring doctor:

If "No", please indicate how the patient came to consult at your hospital/clinic? (e.g. A&E.)

4) Have you referred the patient to any other doctor? Yes No
 If "Yes", please advise:
 (i) Date referred (ddmmyyyy):

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 (ii) Reason for referral:
 (iii) Name and address of doctor referred to:

5) Does the patient have or ever have had any significant health conditions, medical history, or any illness (e.g. diabetes, hypertension, hyperlipidaemia, anaemia, etc.) Yes No
 If "Yes", please advise:

<u>Details of symptoms</u>	<u>Exact diagnosis</u>	<u>Date diagnosed</u>	<u>Treatment</u>
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6) Name and address of doctor whom the patient consulted for the condition(s) stated in Question 5) above:

7) What is your source of the above information?

8) Please provide details of the patient's past and present **smoking** habits, including the duration of smoking habits, number of cigarettes smoked per day and source of this information.

<u>No. of years of smoking</u>	<u>No. of sticks per day</u>	<u>Source of information</u>
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9) Please provide details of the patient's **alcohol consumption** habits, including the amount of the alcohol consumption, frequency, and the source of this information.

<u>Type of alcohol</u>	<u>Quantity per Consumption</u>	<u>Frequency (per week / month, etc.)</u>	<u>Source of information</u>
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C) Details of Illness

1) Please provide details of condition:
 (i) Date the patient **First** consulted you for the condition (ddmmyyyy):

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(ii) Details of symptom(s) presented at **First** consultation:

(iii) Date of onset of these symptoms (ddmmyyyy):

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(iv) What is/are the underlying cause(s) of the symptoms?

(v) Final Diagnosis of the condition:											
(vi) ICD-10 Code:											
(vii) Date of First diagnosis (ddmmyyyy)	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>										
(viii) Date the patient First became aware of the illness/condition (ddmmyyyy)	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>										
2) Name and address of the doctor who First diagnosed the patient with the condition:											
3) Please provide full details and results of all investigations (with dates) performed for the diagnosis. Also, please attach a copy of all the relevant test reports.											
4) Has the patient previously suffered from the condition? <input type="checkbox"/> Yes <input type="checkbox"/> No											
If "Yes", please advise:											
<u>Date of First diagnosis</u>	<u>Exact diagnosis</u>										
<u>Name of doctor and Address of hospital/clinic</u>											
5) What is the prognosis of the patient's condition?											

6) Was the patient admitted to a hospital for treatment of the diagnosis?

Yes No

If "Yes", please advise:

	Hospitalisation Period (including Intensive Care Unit (ICU))		Hospitalisation Period in Intensive Care Unit (ICU)	
	Admission Date (ddmmyyyy)	Discharge Date (ddmmyyyy)	Admission to ICU (ddmmyyyy)	Discharge from ICU (ddmmyyyy)
Name of the hospital				

D) Adrenalectomy for Adrenal Adenoma

1) Was the patient diagnosed of Adrenal Adenoma?

Yes No

2) Did the patient undergo Adrenalectomy?

Yes No

If "Yes", please advise:

(i) Date of surgery (ddmmyyyy):

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(ii) Was the undergoing of Adrenalectomy for treatment of poorly controlled systemic hypertension that was:

a) Secondary to an aldosterone secreting adrenal adenoma?

Yes No

b) Uncontrolled by medical therapy?

Yes No

If "Yes", please advise the medical therapy:

(iii) Was the Adrenalectomy deemed necessary for the management of poorly controlled hypertension?

Yes No

E) Chronic Adrenal Insufficiency (Addison's Disease)

- 1) Was the patient diagnosed of Adrenal Insufficiency which is causing a gradual destruction of the adrenal gland? Yes No
If "Yes", please advise:
- (i) Was the Adrenal Insufficiency an autoimmune disorder? Yes No
If "No", what is the cause of the Adrenal Insufficiency?
- (ii) Does the patient require life long glucocorticoid and mineral corticoid replacement therapy? Yes No
If "Yes", please advise:
Date of Treatment (ddmmyyy) Type of Treatment
- (iii) Was the Adrenal Insufficiency confirmed by
- a) ACTH simulation tests? Yes No
If "Yes", please state the readings:
- b) Insulin-induced hypoglycaemia test? Yes No
If "Yes", please state the readings:
- c) Plasma ACTH level measurement? Yes No
If "Yes", please state the readings:
- d) Plasma Renin Activity (PRA) level measurement? Yes No
If "Yes", please state the readings:
- e) Others? Yes No
If "Yes" to e), please state the test(s) and the corresponding reading(s):

F) Pheochromocytoma

1) Was the patient diagnosed of Pheochromocytoma? Yes No

2) Was a biopsy performed to investigate the tumour? Yes No

If "Yes", please provide:

Date of biopsy (ddmmyyyy):

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Detail of the biopsy:

If "No", please advise on the clinical basis for the diagnosis of the histological nature of the tumour:

3) Was the tumour considered as
(i) Neuroendocrine tumour of adrenal that secretes excess catecholamines? Yes No

(ii) Extra-adrenal chromaffin tissue that secretes excess catecholamines? Yes No

If "No", please provide the supporting reason(s).

G) Other Information

1) Is the patient's diagnosis directly or indirectly, wholly or partly caused by, arising from, or contributed to by any of the following?

(i) Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) infection? Yes No

If "Yes", please advise:

Date of Diagnosis of AIDS/HIV (ddmmyyyy):

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Date the patient **First** became aware of the condition (ddmmyyyy):

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(ii) Wilful misuse of alcohol? Yes No

(iii) Wilful misuse of drugs? Yes No

(iv) Congenital anomaly or defect? Yes No

If "Yes" for any of the above, please advise:

Condition	Name and Address of doctor who First diagnosed the patient	Date of Diagnosis (ddmmyyyy)	Date the patient First became aware of the condition (ddmmyyyy)	Blood Alcohol Concentration Level	Name of Drugs	Quantity of Drugs consumed
HIV or AIDS infection		Not Applicable				
Congenital anomaly or defect				Not Applicable		
Wilful misuse of alcohol			Not Applicable		Not Applicable	
Wilful misuse of drugs			Not Applicable			

Please provide a copy of the relevant test result(s).

2) Is there anything in the patient's **lifestyle** or **personal medical history** that may have increased the risk of the condition? Yes No

If "Yes", please advise:

Type of Lifestyle / Exact diagnosis

Date of diagnosis

Name of doctor & address of hospital/clinic

<p>3) Is there anything in the patient's family history that may have increased the risk of the condition? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes", please advise:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 25%; border-bottom: 1px solid black;"><u>Relationship with patient</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Nature of condition</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Age of onset</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Source of information</u></td> </tr> </table>	<u>Relationship with patient</u>	<u>Nature of condition</u>	<u>Age of onset</u>	<u>Source of information</u>
<u>Relationship with patient</u>	<u>Nature of condition</u>	<u>Age of onset</u>	<u>Source of information</u>	
<p>4) Have active treatment and therapy now been rejected in favour of relief of symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes", please provide full details and explain the reason for this course of action.</p>				
<p>5) Based on the Last consultation and despite all reasonable medical treatment, is the condition highly likely to lead to death within the next:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 80%;">(i) Six (6) months?</td> <td style="width: 20%; text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>(ii) Twelve (12) months?</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table> <p>If "Yes" to (i) and/or (ii), please advise:</p> <p>a) Medical treatment(s) that had been provided to the patient:</p> <p>b) Prognosis after undergoing the mentioned medical treatment(s):</p> <p>c) Any other details on the basis of your evaluation:</p>	(i) Six (6) months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	(ii) Twelve (12) months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(i) Six (6) months?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
(ii) Twelve (12) months?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
<p>6) Please describe and elaborate on the nature and severity of the patient's physical disability and limitation(s).</p>				
<p>7) Please describe and elaborate on the nature and severity of the patient's mental disability and limitation(s), including the degree of cognitive and/or intellectual impairment.</p>				
<p>8) (i) Is the patient mentally incapacitated? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(ii) If the patient is mentally incapacitated, is he/she mentally capable of receiving or handling money? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>				

9) Are you aware of any other doctor(s), in Singapore or overseas, whom the patient consulted for the **condition or any other related diseases?** Yes No

If "Yes", please advise:

Name of doctor and Address of hospital/clinic

Date of **First & Last** consultation

Reasons for consultation

10) Is the patient still on follow-up at your hospital/clinic? Yes No

If "Yes", please state date of next appointment (ddmmyyyy):

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If "No", please state date of discharge (ddmmyyyy), if any:

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11) Please provide us with any other additional information that may assist the Company in assessing this claim.

Please enclose copies all investigation reports including specialist, hospital and laboratory reports. Where applicable, please include the following:

- (i) ACTH reports
- (ii) Biopsy reports, cytology reports, histopathology reports
- (iii) Blood test reports
- (iv) Computerised tomography scan (CT scan)
- (v) X-Ray
- (vi) Operation reports, surgical reports
- (vii) Referral letters (if any)
- (viii) Any other investigation reports

H) Declaration

I hereby declare that the above answers are true to the best of my knowledge and belief.

Signature of Doctor	Address & Official Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	