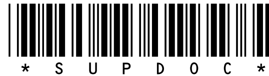

# Critical Illness Claim - Doctor's Statement
## Persistent Vegetative State (Apallic Syndrome) / Akinetic Mutism / Locked in Syndrome

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

**A) Patient's Particulars**

| Name of Patient | Gender |
|---|---|
| NRIC/FIN or Passport No. | Date of Birth (ddmmyyyy) |

**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):

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

(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):

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 advise:

(i) Date referred (ddmmyyyy)

(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

(i) Date referred (ddmmyyyy):

(ii) Reason for referral:

(iii) Name and address of doctor referred to:



**Singapore Life Ltd.** • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

5) Does the patient have or ever have had any significant health conditions, medical history, or any illness (e.g. tumour, hepatitis, diabetes, hypertension, history of accidents/falls, etc.)? ❐ Yes ❐ No

If "Yes", please advise:

| Details of symptoms | Exact diagnosis | Date diagnosed | Treatment |
|---|---|---|---|
| | | | |

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.

| No. of years of smoking | No. of sticks per day | Source of information |
|---|---|---|
| | | |

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.

| Type of alcohol | Quantity per Consumption | Frequency (per week / month, etc.) | Source of information |
|---|---|---|---|
| | | | |

**C) Details of Illness**

1) Please provide details of the condition:

(i) Date the patient **First** consulted you for the condition (ddmmyyyy):

(ii) Details of symptom(s) presented at first consultation:

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

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

(v) **Final** Diagnosis of the condition:

(vi) ICD-10 Code:



**Singapore Life Ltd.** • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

(vii) Date of **First** diagnosis (ddmmyyyy)

(viii) Date the patient **First** became aware of the illness/condition (ddmmyyyy)

2) Please describe the cause of the Apallic Syndrome (e.g. brain injury, brain metabolic disorder, central nervous system abnormalities).

3) Name and address of the Neurologist who **First** diagnosed the patient with the condition:

4) 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.

5) Was the condition a result of an **Accident**? ❒ Yes ❒ No

If "Yes", please advise:

(i) Date of Accident (ddmmyyyy)

(ii) Time of Accident (a.m. / p.m.)

(iii) Place of Accident:

(iv) Describe in detail how the accident happened:

(v) Describe the extent and severity of the bodily injuries/disability sustained, including exact site(s) of the body:

(vi) Was the accident reported to the police? ❒ Yes ❒ No

If "No", why not?

If "Yes", please provide the following information and **attach** a copy of the police report.

Police Division

Name of Police Officer-in-charge



**Singapore Life Ltd.** • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

| | | |
|---|---|---|
| 6) | Did the patient have any medical condition(s) that had contributed to the accident (e.g. fits)?<br>If "Yes", please provide full details. | ❒ Yes ❒ No |
| 7) | Is there presence of universal necrosis of the brain cortex with the brainstem intact?<br>If "Yes", please provide full details, including the neurological deficit. | ❒ Yes ❒ No |
| 8) | Is there organic brain damage which resulted in the patient being unable to talk or move despite appearing alert at times?<br>If "Yes", please provide full details, including the organic brain damage. | ❒ Yes ❒ No |
| 9) | Is the patient unable to move or communicate verbally due to complete paralysis of all voluntary muscles in the body? | ❒ Yes ❒ No |
| 10) | Is there vertical eye movements and blinking? | ❒ Yes ❒ No |
| 11) | Is there evidence of | |
| | (i) Quadriplegia and inability to speak? | ❒ Yes ❒ No |
| | (ii) Infarction of the ventral pons? | ❒ Yes ❒ No |
| | (iii) Electroencephalogram (EEG) indicating that the person is not unconscious? | ❒ Yes ❒ No |
| 12) | Did the Apallic Syndrome and its related conditions persist for at least one month since its onset?<br>If "Yes", please indicate the duration that the patient been suffering from Apallic Syndrome and its related conditions.<br><br>**Please attach a copy of the medical documentation.** | ❒ Yes ❒ No |
| 13) | Is the patient's condition expected to improve?<br>If "Yes", please indicate the extent of recovery and the time frame for such recovery to take place:<br><br>If "No", please support with evidence: | ❒ Yes ❒ No |

14) Please provide full details of the treatment received, including the date(s) (e.g. name of medication, type of surgery, therapy etc.):

15) 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) | |
|---|---|---|---|---|
| Name of the hospital | Admission Date (ddmmyyyy) | Discharge Date (ddmmyyyy) | Admission to ICU (ddmmyyyy) | Discharge from ICU (ddmmyyyy) |
| | | | | |
| | | | | |



**Singapore Life Ltd.** • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

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

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

If "Yes", please provide details:

Date of Diagnosis of AIDS/HIV (ddmmyyyy): | | | | | | | | |

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

(ii) Wilful misuse of alcohol? ❒ Yes ❒ No

(iii) Wilful misuse of drugs? ❒ Yes ❒ No

(iv) Congenital anomaly or defect? ❒ Yes ❒ No

(v) Self-inflicted act? ❒ Yes ❒ No

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

| | **Name and Address of doctor who First diagnosed the patient** | **Date of Diagnosis (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 | |
| Wilful misuse of drugs | | | Not Applicable | | |

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

**D) Other Information**

1) What is the prognosis of the patient's condition?

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 |
| --- | --- | --- |

3) Is there anything in the patient's **family history** that may have increased the risk of the condition? ❒ Yes ❒ No

If "Yes", please advise:

| Relationship with patient | Nature of condition | Age of onset | Source of information |
| --- | --- | --- | --- |

4) Have active treatment and therapy been rejected in favour of the relief of symptoms? ❒ Yes ❒ No

If "Yes", please provide full details and explain the reason for this course of action.

5) Based on the **Last** consultation and despite all reasonable medical treatment, is the condition highly likely to lead to death within the next:

(i) Six (6) months? ❒ Yes ❒ No

(ii) Twelve (12) months? ❒ Yes ❒ No

If "Yes" to (i) and/or (ii), please advise:

a) Medical treatment(s) that had been provided to the patient:

b) Prognosis after undergoing the mentioned medical treatment(s):

c) Any other details on the basis of your evaluation:

6) Please describe and elaborate on the nature and severity of the patient's **physical** disability and limitation(s).



**Singapore Life Ltd.** • singlife.com

Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

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.

8) (i) Is the patient mentally incapacitated? ❒ Yes ❒ No

(ii) If the patient is mentally incapacitated, is he/she mentally capable of receiving or handling money? ❒ Yes ❒ No

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): ☐☐☐☐☐☐☐☐

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

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

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

(i) Blood test reports
(ii) Computerised tomography scan (CT scan)
(iii) Magnetic resonance imaging (MRI), other imaging studies
(iv) X-Ray
(v) Operation reports, surgical reports
(vi) Referral letters (if any)
(vii) Any other investigation reports



**Singapore Life Ltd.** • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

| **E) Declaration** | |
|---|---|
| I hereby declare that the above answers are true to the best of my knowledge and belief. | |
| Signature of Doctor | Address & Offical Stamp of Doctor |
| Name of Doctor | |
| Date (ddmmyyyy) | |



**Singapore Life Ltd.** • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8