



Living Benefit Claim - Doctor's Statement Pre-Eclampsia or Eclampsia

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) <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																
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): <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> (ii) Date of Last consultation (ddmmyyyy): <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> (iii) Number of consultations during the above period: (iv) Name of hospital/clinic and reasons for consultations (with dates):																	
2) Are you the patient's usual medical doctor? ☐ Yes ☐ No If "Yes", since when? (ddmmyyyy): <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> 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): <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> (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): <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> (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. tumour, diabetes, hypertension, hyperlipidaemia, anaemia etc.)? If "Yes", please advise: <u>Details of symptoms</u> <u>Exact diagnosis</u> <u>Date diagnosed</u> <u>Treatment</u>	☐ Yes ☐ No
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 give details of the patient's past and present smoking habit(s), 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>	
9) Please give details of the patient's alcohol consumption habit(s), 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>	

C) Details of Illness

1) Please provide details of the condition:									
(i) Date the patient First consulted you for the condition (ddmmyyyy):	<table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td> </tr> </table>								
(ii) Details of symptom(s) presented at First consultation:									
(iii) Date of onset of these symptoms (ddmmyyyy):	<table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td> </tr> </table>								
(iv) Final Diagnosis of the condition:									
(v) ICD-10 Code:									
(vi) Date of First diagnosis (ddmmyyyy):	<table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td> </tr> </table>								
(vii) Date the patient First became aware of the illness/condition (ddmmyyyy):	<table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td> </tr> </table>								

- 2) Please provide full details and results of all **investigation(s)** (with dates) performed for the diagnosis.
Also, please **attach** a copy of all relevant test reports.

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

- 4) Was there hypertension developing after 20 weeks of pregnancy?

☐ Yes ☐ No

- 5) What were the highest Blood Pressure readings recorded on 2 successive measurements of at least 6 hours apart post 20 weeks of pregnancy?

☐ Yes ☐ No

If "Yes", please advise:

- (i) **First** Reading Taken: Date (ddmmyyyy), time and its reading:

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Time: _____ Systolic: _____ mmHg

Diastolic: _____ mmHg

- (ii) **Next** Reading Taken: Date (ddmmyyyy), time and its reading:

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Time: _____ Systolic: _____ mmHg

Diastolic: _____ mmHg

6) Was there associated proteinuria of (i) more than 3+ on a random urine sample? (ii) more than 1+ on a random urine sample? Please advise the details and reading:	☐ Yes ☐ No ☐ Yes ☐ No
7) Was there protein/creatinine ratio > 0.3 mg/mg on a random urine sample? If "Yes", please advise the details and reading:	☐ Yes ☐ No
8) Please state the number of gestational weeks before the birth of the baby:	
9) Was this pregnancy conceived through any of the following fertility treatments: (i) Vitro Fertilization (IVF): (ii) Intra-Cytoplasmic Sperm (ICSI): (iii) Intrauterine Insemination (IUI): (iv) Intracervical Insemination (ICI): If none of the above, please specify the fertility treatment that the patient has received:	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
10) Was the patient carrying 5 or more babies during this pregnancy? If "No", please indicate the number of babies that the patient carried during the pregnancy.	☐ Yes ☐ No

11) 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 provide details:

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) Deliberate misuse of alcohol? ☐ Yes ☐ No

(iii) Deliberate misuse of drugs? ☐ Yes ☐ No

(iv) Self-inflicted illness, injury, suicide or attempted suicide? ☐ Yes ☐ No

(v) Use of unprescribed drugs where such drugs are required by law to be prescribed by a registered medical practitioner? ☐ Yes ☐ No

(vi) Pregnancy complications from fertility treatments? ☐ Yes ☐ No

(vii) Elective abortions? ☐ Yes ☐ No

(viii) Complications arising from child delivery in overseas hospitals and hospitalisation occurring overseas? ☐ 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				
Deliberate misuse of alcohol			Not Applicable		Not Applicable	
Deliberate misuse of drugs			Not Applicable			

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

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

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

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

D) Declaration

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

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Signature of Doctor

Address & Official Stamp of Doctor

Name of Doctor

Date (ddmmyyyy)