



### Living Benefit Claim - Doctor's Statement Amniotic Fluid Embolism

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

<b>A) Patient's Particulars</b>									
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>B) Patient's Medical Records</b>									
1) Please indicate the period that is documented in the hospital/clinic's record:									
(i) Date of <b>First</b> 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 <b>Last</b> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.)?  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 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.  
No. of years of smoking                      No. of sticks per day                      Source of information

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.  
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 (ddmmyyy): 

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

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

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

(v) ICD-10 Code:

(vi) Date of **First** diagnosis (ddmmyyy): 

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(vii) Date the patient **First** became aware of the illness/condition (ddmmyyy): 

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<p>2) Please provide full details and results of all <b>investigation(s)</b> (with dates) performed for the diagnosis. Also, please <b>attach</b> a copy of all relevant test reports.</p>																		
<p>3) Name and address of the doctor who <b>First</b> diagnosed the patient with the condition:</p>																		
<p>4) Was there presence of:</p> <table style="width: 100%; border: none;"> <tr> <td style="padding-left: 20px;">(i) Acute respiratory distress and shock:</td> <td style="text-align: right;"><input type="checkbox"/> Yes</td> <td style="text-align: right;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding-left: 20px;">(ii) Respiratory distress:</td> <td style="text-align: right;"><input type="checkbox"/> Yes</td> <td style="text-align: right;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding-left: 20px;">(iii) Cardiovascular collapse:</td> <td style="text-align: right;"><input type="checkbox"/> Yes</td> <td style="text-align: right;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding-left: 20px;">(iv) Disseminated intravascular coagulation:</td> <td style="text-align: right;"><input type="checkbox"/> Yes</td> <td style="text-align: right;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding-left: 20px;">(v) Coma:</td> <td style="text-align: right;"><input type="checkbox"/> Yes</td> <td style="text-align: right;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding-left: 20px;">(vi) Pulmonary embolism as evident on lung scans:</td> <td style="text-align: right;"><input type="checkbox"/> Yes</td> <td style="text-align: right;"><input type="checkbox"/> No</td> </tr> </table> <p>If "Yes", please provide copy of the investigation results to support:</p>	(i) Acute respiratory distress and shock:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(ii) Respiratory distress:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(iii) Cardiovascular collapse:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(iv) Disseminated intravascular coagulation:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(v) Coma:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(vi) Pulmonary embolism as evident on lung scans:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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<p>5) What was the underlying cause of amniotic fluid embolism?</p>																		
<p>6) Was this pregnancy conceived through any of the following fertility treatments:</p> <table style="width: 100%; border: none;"> <tr> <td style="padding-left: 20px;">(i) Vitro Fertilization (<b>IVF</b>):</td> <td style="text-align: right;"><input type="checkbox"/> Yes</td> <td style="text-align: right;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding-left: 20px;">(ii) Intra-Cytoplasmic Sperm (<b>ICSI</b>):</td> <td style="text-align: right;"><input type="checkbox"/> Yes</td> <td style="text-align: right;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding-left: 20px;">(iii) Intrauterine Insemination (<b>IUI</b>):</td> <td style="text-align: right;"><input type="checkbox"/> Yes</td> <td style="text-align: right;"><input type="checkbox"/> No</td> </tr> <tr> <td style="padding-left: 20px;">(iv) Intracervical Insemination (<b>ICI</b>):</td> <td style="text-align: right;"><input type="checkbox"/> Yes</td> <td style="text-align: right;"><input type="checkbox"/> No</td> </tr> </table> <p>If none of the above, please specify the fertility treatment that the patient has received:</p>	(i) Vitro Fertilization ( <b>IVF</b> ):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(ii) Intra-Cytoplasmic Sperm ( <b>ICSI</b> ):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(iii) Intrauterine Insemination ( <b>IUI</b> ):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(iv) Intracervical Insemination ( <b>ICI</b> ):	<input type="checkbox"/> Yes	<input type="checkbox"/> No						
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(iv) Intracervical Insemination ( <b>ICI</b> ):	<input type="checkbox"/> Yes	<input type="checkbox"/> No																
<p>7) Was the patient carrying 5 or more babies during this pregnancy? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>If "No", please indicate the <b>number</b> of babies that the patient carried during the pregnancy.</p>																		

8) 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).

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

**D) 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)