



**Critical Illness Claim - Doctor's Statement  
Severe Bacterial Meningitis / Bacterial Meningitis**

**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)									
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<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" style="width:100%; height: 20px;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> </tr> </table>									
(ii) Date of <b>Last</b> consultation (ddmmyyyy):						<table border="1" style="width:100%; height: 20px;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></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? <span style="float:right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>															
If "Yes", since when? (ddmmyyyy):						<table border="1" style="width:100%; height: 20px;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> </tr> </table>									
If "No", please provide name and address of the patient's regular doctor:															
3) Was the patient referred to you? <span style="float:right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>															
If "Yes", please provide:															
(i) Date referred (ddmmyyyy):						<table border="1" style="width:100%; height: 20px;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></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? <span style="float:right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>															
(i) Date referred (ddmmyyyy):						<table border="1" style="width:100%; height: 20px;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></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. brain herniation, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, etc.)? If "Yes", please advise: <u>Details of symptoms</u> <u>Exact diagnosis</u> <u>Date diagnosed</u> <u>Treatment</u>	<input type="checkbox"/> Yes <input type="checkbox"/> 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 provide details of the patient's past and present <b>smoking</b> 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 provide details of the patient's <b>alcohol consumption</b> 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>	

<b>C) Details of Illness</b>											
1) Please provide details of the condition:											
(i) Date the patient <b>First</b> consulted you for the condition(ddmmyyy):	<table border="1" style="width: 100%; height: 20px; 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> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
(ii) Details of symptom(s) presented at <b>First</b> consultation:											
(iii) Date of onset of these symptoms (ddmmyyy):	<table border="1" style="width: 100%; height: 20px; 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> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
(iv) What is/are the underlying cause(s) of the symptoms?											
(v) <b>Final</b> Diagnosis of the condition:											
(vi) ICD-10 Code:											

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

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

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- 2) Is there any severe inflammation of the membranes of the brain or spinal cord?  Yes  No  
If "Yes", were appropriate investigations (including Lumbar puncture test) performed to prove the severe inflammation of the membranes of the brain or spinal cord?  Yes  No  
Please describe in full details (with dates) of the investigations performed.

Date of investigations (ddmmyyyy)	Types of investigations performed	Details of investigations

Please **attach** a copy of relevant test reports.

- 3) Please describe in full details (with dates) the extent of neurological deficits.

Date of initial episode (ddmmyyyy)	Types of neurological deficits experienced	Duration of symptoms

4) Was there any neurological deficit (described in Question 3) lasting for a **continuous** period of at least six (6) weeks?

Yes  No

If “Yes”, please provide details on the permanent neurological deficit with persisting clinical symptoms which indicate symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the lifetime of the patient:

Please tick	Neurological deficit	Date of last review confirming the neurological deficit (ddmmyyy)	Please specify the exact body part(s) affected	Is the neurological deficit permanent and expected to last throughout the lifetime?	Please elaborate with supporting evidence
	Numbness			Yes / No	
	Paralysis			Yes / No	
	Localised weakness			Yes / No	
	Dysarthria (difficulty with speech)			Yes / No	
	Aphasia (inability to speak)			Yes / No	
	Dysphagia (difficulty swallowing)			Yes / No	
	Visual Impairment			Yes / No	
	Difficulty in walking			Yes / No	
	Lack of coordination			Yes / No	
	Tremor			Yes / No	
	Seizures			Yes / No	
	Dementia			Yes / No	
	Delirium			Yes / No	
	Coma			Yes / No	
	Others, please specify:			Yes / No	

5) Are the neurological deficits irreversible?  Yes  No

(i) If "Yes", please elaborate with supporting evidence:

(ii) If "No", please state date of recovery or date for which the patient is likely to recover from these neurological deficits (ddmmyyy):

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6) Please provide full details and results of **investigation(s)** performed (with dates) performed for the diagnosis. Also, please **attach** a copy of all relevant test reports for affected areas including **the cerebrospinal fluid and blood culture, stating the types of organism(s) found for each area etc.**

7) What was the cerebrospinal fluid collection method?

8) Was lumbar puncture performed for the collection of cerebrospinal fluid?  Yes  No

9) Was there any presence of bacterial infection in cerebrospinal fluid by lumbar puncture?  Yes  No

If "Yes", were there appropriate investigation(s) (including Lumbar puncture test) performed to prove the bacterial infection?

Yes  No

Please describe in full details (with dates) of the investigations performed.

Date of investigations (ddmmyyy)	Types of investigations performed	Details of investigations

Please **attach** a copy of all relevant test reports.

10) Name and address of the **neurologist** who **First** diagnosed the patient with the condition:

11) Please provide details of ongoing **treatment**, including name and dosage of medication, operation contemplated (if any).

12) 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				

13) Is the patient's diagnosis or surgery 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 (ddmmyyy):

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Date the patient First became aware of the condition (ddmmyyy):

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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 (ddmmyyy)	Date the patient First became aware of the condition (ddmmyyy)	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).

<b>D) Other Information</b>	
1) What is the prognosis of the patient's condition?	
2) Is there anything in the patient's <b>lifestyle</b> or <b>personal medical history</b> that may have increased the risk of the condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", please advise: <u>Type of Lifestyle / Exact diagnosis</u> <u>Date of diagnosis</u> <u>Name of doctor &amp; address of hospital/clinic</u>	
3) Is there anything in the patient's <b>family history</b> that may have increased the risk of the condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", please advise: <u>Relationship with patient</u> <u>Nature of condition</u> <u>Age of onset</u> <u>Source of information</u>	
4) Have active treatment and therapy now been rejected in favour of relief of symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", please provide full details and explain the reason for this course of action.	
5) Based on the <b>Last</b> consultation and despite all reasonable medical treatment, is the condition highly likely to lead to death within the next:	
(i) Six (6) months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(ii) Twelve (12) months?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 <b>physical</b> disability and limitation(s).	

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.

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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

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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:

<u>Name of doctor and Address of hospital/clinic</u>	<u>Date of <b>First &amp; Last</b> consultation</u>	<u>Reasons for consultation</u>
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10) Is the patient still on follow-up at your hospital/clinic?  Yes  No

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

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If "No", please state date of discharge (ddmmyyy), if any. 

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

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

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

**E) 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 (ddmmyyy)