



**Critical Illness Claim - Doctor's Statement
Special Benefit - Severe Rheumatoid Arthritis**

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> </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> </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> </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> </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> </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> </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. cyst, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, frequent falls, etc.) Yes No
 If "Yes", please advise:

<u>Details of symptoms</u>	<u>Exact diagnosis</u>	<u>Date diagnosed</u>	<u>Treatment</u>

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** 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 **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 (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) 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 (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> </tr> </table>																					
(viii) Date the patient First became aware of the illness/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> </tr> </table>																					
<p>2) Is there evidence of widespread joint destruction with major clinical deformity of the joint areas of</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 80%;">(i) Hands:</td> <td style="text-align: right;"><input type="checkbox"/> Yes</td> <td style="text-align: right;"><input type="checkbox"/> No</td> </tr> <tr> <td>(ii) Wrists:</td> <td style="text-align: right;"><input type="checkbox"/> Yes</td> <td style="text-align: right;"><input type="checkbox"/> No</td> </tr> <tr> <td>(iii) Elbows:</td> <td style="text-align: right;"><input type="checkbox"/> Yes</td> <td style="text-align: right;"><input type="checkbox"/> No</td> </tr> <tr> <td>(iv) Spine:</td> <td style="text-align: right;"><input type="checkbox"/> Yes</td> <td style="text-align: right;"><input type="checkbox"/> No</td> </tr> <tr> <td>(v) Knee:</td> <td style="text-align: right;"><input type="checkbox"/> Yes</td> <td style="text-align: right;"><input type="checkbox"/> No</td> </tr> <tr> <td>(vi) Ankle:</td> <td style="text-align: right;"><input type="checkbox"/> Yes</td> <td style="text-align: right;"><input type="checkbox"/> No</td> </tr> <tr> <td>(vii) Feet:</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" to any of the above, please provide details to your answer:</p>		(i) Hands:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(ii) Wrists:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(iii) Elbows:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(iv) Spine:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(v) Knee:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(vi) Ankle:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(vii) Feet:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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<p>3) Has the patient suffered from any of the following symptoms?</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 80%;">(i) Morning stiffness:</td> <td style="text-align: right;"><input type="checkbox"/> Yes</td> <td style="text-align: right;"><input type="checkbox"/> No</td> </tr> <tr> <td>(ii) Symmetric arthritis:</td> <td style="text-align: right;"><input type="checkbox"/> Yes</td> <td style="text-align: right;"><input type="checkbox"/> No</td> </tr> <tr> <td>(iii) Presence of rheumatoid nodules:</td> <td style="text-align: right;"><input type="checkbox"/> Yes</td> <td style="text-align: right;"><input type="checkbox"/> No</td> </tr> </table>		(i) Morning stiffness:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(ii) Symmetric arthritis:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(iii) Presence of rheumatoid nodules:	<input type="checkbox"/> Yes	<input type="checkbox"/> No												
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(iii) Presence of rheumatoid nodules:	<input type="checkbox"/> Yes	<input type="checkbox"/> No																				
<p>4) Is there evidence of elevated titres of rheumatoid factor(s): <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide a copy of the test report(s) and state the results that indicate elevated titres of rheumatoid factors:</p>																						
<p>5) Is there evidence of Radiographic evidence of severe involvement? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide a copy of the Radiographic evidence report(s) that indicate severe involvement:</p>																						
<p>6) Name and address of the rheumatologist who First diagnosed the patient with the condition:</p> 																						
<p>7) Please provide full details and results of all investigation(s) (with dates) performed for the diagnosis. Also, please attach a copy of all the relevant test reports.</p> 																						

8) Please provide details of current **treatment**, including name and dosage of medication, occupational or physical therapy (if any):

9) 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				

10) 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:

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

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(b) 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).

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?	<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 & address of hospital/clinic</u>
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
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 been rejected in favour of the 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 Last 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 **physical** 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.

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):

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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 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) X-Ray
- (v) Operation reports, surgical reports
- (vi) Referral letters (if any)
- (vii) 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 (ddmmyyyy)	