



**Critical Illness Claim - Doctor's Statement
Coma / Coma for 48 Hours / Severe Epilepsy**

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" 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>								
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" 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>								
(ii) Date of Last Consultation (ddmmyyyy)	<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>								
(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? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If "Yes", since when? (ddmmyyyy)	<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>								
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" 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>								
(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" 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>								
(ii) Reason for referral:									
(iii) Name and address of doctor referred to:									

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

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

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

4) Is the diagnosis because of an **Accident**? Yes No

If "Yes", please advise:

(i) Date of Accident (ddmmyyyy).

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(ii) Time of Accident.

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 a.m. / p.m.

(iii) Place of Accident.

(iv) Describe in detail how the accident happened.

(v) Describe the extent and severity of the brain, facial, spinal cord and/or 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

(vii) Did the patient have any medical condition(s) that had contributed to the accident (e.g. fits) Yes No

If "Yes", please provide details.

5) Is the diagnosis directly from:
(i) a medically induced coma? Yes No

If "Yes", please provide full details including reasons for the medically induced coma, diagnosis date, name of doctor and Hospital/Clinic who **First** diagnosed the patient with medically induced coma.

Please provide copy of test result.

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

(i) Self-inflicted act? Yes No

(ii) Wilful misuse of alcohol? Yes No

(iii) Wilful misuse of drugs? Yes No

If "Yes", please provide full details including reasons for the self-inflicted act, result of blood alcohol concentration, name of drugs, quantity consumed, diagnosis date, name of doctor and hospital/clinic where the patient was **First** diagnosed with self-inflicted act, wilful misuse of alcohol or wilful misuse of drugs.

Please provide copy of test result.

7) How many hours was the patient in a state of coma, with no response to external stimuli?

	hours
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8) Was the patient put on life support measures? Yes No

If "Yes", please advise:

(i) Date the patient was put on life support measures (ddmmyyyy)

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(ii) Details of such life support measures.

9) Had the patient emerged from the state of coma, with no response to external stimuli? Yes No

If "Yes", please advise:

(i) Date he/she emerged from the state of coma (ddmmyyyy)

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(ii) Time he/she emerged from the state of coma.

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a.m. / p.m.

10) Was there any brain damage that resulted in permanent neurological deficit which was assessed thirty (30) days after the onset of the coma? Yes No

If "Yes", please advise:

(i) Date of the assessment (ddmmyyyy)

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(ii) Details of the permanent neurological deficit and attach a copy of the report(s).

11) Has there been any improvement in the patient's condition since the onset of coma? Yes No

Please provide the basis of your evaluation.

12) Is the patient diagnosed with **Epilepsy**? Yes No

If "Yes", please advise:

(i) How was the diagnosis of Epilepsy established?

(ii) Please attach copies of diagnostic reports (i.e. Electroencephalography (EEG), Magnetic Resonance Imaging (MRI), Position Emission Tomography (PET) or other test report).

(iii) Has the patient experienced recurrent unprovoked tonic-clonic or grand mal seizures and be known to be resistant to optimal therapy as confirmed by drug serum level testing? Yes No

If "Yes", please provide:

(a) Dates of Attack (ddmmyyyy)

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(b) Frequency of such attacks per week:

(iv) Is the patient taking prescribed anti-epileptic (anti-convulsant) medications recommended by a neurologist? Yes No

If "Yes", please advise:

Type(s)/Name(s) of medication prescribed	Date of commencement of medication(s) (ddmmyyyy)	Duration that the patient has taken the medication(s) till date

(v) Would you consider the patient to be an optimal drug therapy? Yes No
If "Yes", please provide the period the patient has been on such anti-epileptic therapy.

D) Other Information

- 1) Was the patient admitted to a hospital for treatment of the diagnosis? Yes No
 If "Yes", please advise:

Name of the hospital	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)

- 2) Is the 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:

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) 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		

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

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

4) 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

5) 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

6) Have active treatment and therapy now been rejected in favour of relief of symptoms? Yes No
If "Yes", please provide full details and explain the reason for this course of action.

7) 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.

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

9) 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.

10) (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

11) 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

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) Echocardiography reports
- (iv) Magnetic resonance imaging (MRI), other imaging studies
- (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)