* S U P D O C *

Critical Illness Claim - Doctor's Statement
Fulminant Viral Hepatitis / Hepatitis with Cirrhosis / Biliary Tract Reconstruction Surgery / Chronic Primary Sclerosing Cholangitis

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) | | | | | | | | |

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) | | | | | | | | |

(ii) Date of **Last** consultation (ddmmyyyy) | | | | | | | | |

(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? ❒ Yes ❒ No

If "Yes", since when? (ddmmyyyy) | | | | | | | | |

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) | | | | | | | | |

(ii) Reason for referral:

(iii) Name and address of referring doctor:

If "No", how 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) | | | | | | | | |

(ii) Reason for referral:

(iii) Name and address of doctor referred to:

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5) Does the patient have or ever have had any significant health conditions, medical history, or any illness (e.g. tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, 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** habits, 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** habits, 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 (ddmmyyyy)

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

(iii) Date of onset of these symptoms (ddmmyyyy)

(iv) What is the underlying cause(s) of the symptoms?

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

(vi) Type(s) of hepatitis virus diagnosed:

(vii) ICD-10 Code:

(viii) Date of **First** diagnosis (ddmmyyyy) | | | | | | | | |

(ix) Date the patient **First** became aware of the illness/condition (ddmm | | | | | | | | |

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

3) Was a liver biopsy performed? ❒ Yes ❒ No

If "Yes", please provide the Date of biopsy (ddmmyyyy) | | | | | | | | |

Attach a copy of the biopsy result.

4) Was an abdominal ultrasound performed? ❒ Yes ❒ No

If "Yes", please provide the Date of the ultrasound (ddmmyyyy) | | | | | | | | |

Attach a copy of the ultrasound result.

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

6) Is there a submassive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure? ❒ Yes ❒ No
If "Yes", please advise:

(i) Is there rapid decreasing of the liver size? ❒ Yes ❒ No

If "Yes", please advise:

(a) The condition of the liver and its lobular architecture:

(b) The mode of detection (e.g. abdominal ultrasound):

(ii) Is there necrosis involving entire lobules, leaving only a collapsed reticular framework? ❒ Yes ❒ No
If "Yes", please advise the extent of the liver necrosis and its lobular architecture.

(iii) Is there a rapid deterioration of liver function tests? ❒ Yes ❒ No
If "Yes", please attach a copy of the results during the period of rapid deterioration.

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(iv) Is there deepening jaundice? ❒ Yes ❒ No
If "Yes", please provide full details.

(v) Is there evidence of hepatic encephalopathy? ❒ Yes ❒ No
If "Yes", please provide details including dates, underlying causes, complications (if any) and treatment.

Please attach a copy of the abdominal ultrasound and any other investigation reports that were done.

7) Was there endoscopy and/or radiological evidence of oesophageal varices? ❒ Yes ❒ No
If "Yes", please advise:
(i) Was there evidence of bleeding from the oesophageal varices? ❒ Yes ❒ No
If "Yes", please provide details of episodes of bleeding, including date and treatment.

Attach a copy of the reports.

8) Is there a submassive necrosis of the liver by the hepatitis virus leading to cirrhosis? ❒ Yes ❒ No
If "Yes", please advise:
(i) a. Histological stage by Metavir grading.

b. Histological stage by Knodell fibrosis score.

Attach a copy of the biopsy result.

(ii) Name of Gastroenterologist and address of hospital who gave the liver cirrhosis diagnosis.

9) Did the patient undergo biliary tract reconstruction surgery involving choledochoenterostomy (choledochojejunostomy or choledochoduodenostomy) for the treatment of biliary tract disease, including biliary atresia? ❒ Yes ❒ No
If "Yes", please advise:
(i) Date of biliary tract reconstruction surgery (ddmmyyyy) | | | | | | | | |

(ii) Is the biliary tract disease not amendable by other surgical or endoscopic measures? ❒ Yes ❒ No

(iii) Is the biliary tract reconstruction surgery considered to be the most appropriate treatment? ❒ Yes ❒ No

(iv) Is the biliary tract reconstruction surgery performed to treat the consequences of gall stone disease or cholangitis? ❒ Yes ❒ No

(v) Name of specialist in hepatobiliary disease and address of hospital who considered the biliary tract reconstruction surgery to be the most appropriate treatment.

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10) Is the diagnosis considered as a chronic primary sclerosing cholangitis confirmed on cholangiogram?
If "Yes", please advise:

(i) Is there progressive obliteration of the bile ducts? ❒ Yes ❒ No

(ii) Is there permanent jaundice? ❒ Yes ❒ No

(iii) Is there Biliary tract sclerosis or obstruction because of biliary surgery, gall stone disease, infection, inflammatory bowel disease or other secondary precipitants? ❒ Yes ❒ No

(iv) Name of Gastroenterologist and address of hospital who gave the diagnosis.

11) Please provide details of **current treatment.**

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)**	
Name of the hospital	Admission Date (ddmmyyyy)	Discharge Date (ddmmyyyy)	Admission to ICU (ddmmyyyy)	Discharge from ICU (ddmmyyyy)

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13) 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:

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

Date the patient **First** became aware of the condition (ddmmyyyy): | | | | | | | | |

(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).

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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 condition? ❒ Yes ❒ No

If "Yes", please advise:

Type of Lifestyle / Exact diagnosis	Date of diagnosis	Name of doctor & address of hospital/clinic

3) 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

4) 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.

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? ❒ 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.

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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 advise date of next appointment (ddmmyyyy) | | | | | | | | |

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

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

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Please enclose copies of all investigation reports including specialist, hospital, laboratory reports that are available. Where applicable, pleace include the following:

(i) Computerised tomography scan (CT scan)
(ii) Endoscopy results
(iii) Magnetic resonance imaging (MRI), other imaging studies
(iv) Liver biopsy reports
(v) Liver/abdominal ultrasound & radiological reports
(vi) Serial liver function tests reports
(vii) X-Ray
(viii) Operation reports, surgical reports
(ix) Referral letters (if any)
(x) 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 & Offical Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	

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