



Critical Illness Claim - Doctor's Statement
End Stage Kidney Failure / Surgical Removal of One Kidney / Chronic Kidney Disease

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:									

5) Does the patient have or ever have had any significant health conditions, medical history, or any illness Yes No
 (e.g. cyst, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, anaemia, etc)
 If "Yes", please advise:
Details of symptoms Exact diagnosis Date diagnosed Treatment

6) Please provide 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 habit(s), 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 Frequency Source of information
Consumption (per week / month, etc)

C) Details of Illness

1) Please provide details of the condition:

(i) Date the patient **First** consulted 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):

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

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

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

4) Please state if the kidney disease has resulted in permanent irreversible kidney function impairment? Yes No
If "Yes", please list the eGFR level readings with dates.
Date eGRF Level Date eGRF Level

5) Is there laboratory evidence indicating that renal function is severely decreased, with GFR < 15mL/min / 1.73m² body surface area? Yes No
If "Yes", please advise:
(i) How long has this result persisted? Days
(ii) Which kidney(s) has/have failed? Kidney(s)

6) Is there laboratory evidence indicating that renal function is severely decreased, with GFR < 30mL/min / 1.73m² body surface area? Yes No
If "Yes", please advise:
(i) How long has this result persisted? Days
(ii) Which kidney(s) has/have failed? Kidney(s)

7) Is there chronic kidney failure of both kidneys?
If "Yes", since when? (ddmmyyyy):

8) Is the renal disease reversible? Yes No

9) Has the kidney failure reached its end stage? Yes No
 If "Yes", since when? (ddmmyyyy):

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10) Does the patient require permanent renal dialysis or kidney transplantation? Yes No

11) Is the patient currently undergoing regular peritoneal dialysis or haemodialysis? Yes No
 If "Yes", please advise:
 (i) Date of **First** dialysis (ddmmyyyy):

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 (ii) Number of dialysis per week:

 Times / Week
 Also, please **attach** copies of hospital/ medical invoices to show the commencement of dialysis treatments.

12) Has kidney transplantation been performed? Yes No
 If "Yes", please advise:
 (i) Date of surgery (ddmmyyyy):

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 (ii) Which kidney(s) was removed?

 Kidney(s)
 (iii) Is the surgical removal medically necessary? Yes No
 If "Yes", please explain.
 (iv) Name and address of doctor who performed the surgery:

Please provide copies of operation report(s).

13) Is the patient a recipient of the kidney transplantation? Yes No

14) Was a complete surgical removal of one kidney performed? If "Yes", please advise: Yes No
 (i) Date of surgery (ddmmyyyy):

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 (ii) Was the surgery considered medically necessary by the nephrologist? Yes No
 If "Yes", please explain:
 (iii) Name and address of doctor who performed the surgery:

Please provide copies of operation report(s).

15) Was the surgical removal of kidney for the purpose of a donation?

Yes No

16) 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)

17) Is the diagnosis or surgery directly or indirectly, wholly or partly caused by or 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) 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 illness</u> <u>Date of diagnosis</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 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:

<u>Name of doctor and Address of hospital/clinic</u>	<u>Date of First & Last 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 (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) Biopsy reports
- (ii) Blood test reports
- (iii) Computerised tomography scan (CT scan)
- (iv) Magnetic resonance imaging (MRI), other imaging studies
- (v) Renal dialysis reports
- (vi) X-Ray
- (vii) Operation reports, surgical reports
- (viii) Referral letters (if any)
- (ix) 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)	