* S U P D O C *

Singlife

Critical Illness Claim - Doctor's Statement
Major Head Trauma / Facial Reconstructive Surgery / Cervical Spinal Cord Injury / Intermediate Stage Major Head Trauma

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", 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? ❒ 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/are the underlying cause(s) of the symptoms?

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

(vi) ICD-10 Code:

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

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

2) 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.

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) | | | | | | | | |

(ii) Time of Accident _____ 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 full details.

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

If "Yes", please provide full details.

5) Is the diagnosis directly or indirectly, wholly, or partly caused by, 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" 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**
Wilful misuse of alcohol			Not Applicable		Not Applicable	
Wilful misuse of drugs			Not Applicable			

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

6) 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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7) Did the patient refuse any form of medical treatment, including surgery, which might have prevented or reduced the severity of the impairment? ❒ Yes ❒ No

If "Yes", please provide full details.

8) If the patient had suffered from

(i) Major Head Trauma, please proceed to **Section D.**

(ii) Facial Injury, proceed to **Section E**.

(iii) Cervical Spinal Cord Injury, proceed to **Section F**.

D) This section is applicable for Major Head Trauma only.

1) Describe the exact nature of the brain injury.

(As the policy specifies that the brain injury must be demonstrated by a modern scanning or imaging techniques, please **attach** a copy of the Magnetic Resonance Imaging or Computerised Tomography Scan.)

2) Was the patient diagnosed of:

(i) head injury? ❒ Yes ❒ No

(ii) spinal cord injury? ❒ Yes ❒ No

(iii) head injury due to other cause? ❒ Yes ❒ No

If yes, please advise the cause:

3) Was there any form of neurological deficit still present 6 weeks after the date of the accident? ❒ Yes ❒ No

If "Yes", please advise:

(i) Full details of the neurological deficits.

(ii) **Date of Last review** confirming the neurological deficit **(**ddmmyyyy)

4) Is the neurological deficit permanent and expected to last throughout the lifetime of the patient? ❒ Yes ❒ No

If "No", please state the date of recovery *or* date for which the patient is expected to recover from the neurological deficit (ddmmyyyy)

If "Yes", please provide details:

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5) Name and address of the neurologist who **First** diagnosed the patient with Major Head Trauma.

6) Was there any surgery done? ❒ Yes ❒ No

If "Yes", please advise:

(i) Date of surgery (ddmmyyyy)

(ii) Nature or type of the surgery performed (e.g. open craniotomy, burr hole surgery, etc.)

(iii) Did the patient undergo open craniotomy? ❒ Yes ❒ No

If "Yes", was it due to consequence of

a) major head trauma for the treatment of depressed skull fractures? ❒ Yes ❒ No

b) major intracranial injury? ❒ Yes ❒ No

(iv) Did the patient undergo burr hole surgery? ❒ Yes ❒ No

Please provide copy of operation report and surgery note.

7) Please provide details of current **treatment**, including any physical and speech therapy, if any.

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E) This section is applicable to Facial Reconstructive Surgery only.

1) Was there any reconstructive surgery above the neck (restoration or reconstruction of the shape of, and appearance of facial structures which were defective, missing or damaged or misshapen) to correct disfigurement as a direct result of the accident? ❒ Yes ❒ No

If "Yes", please advise:

(i) Date of surgery performed (ddmmyyyy) | | | | | | | | |

(ii) Was the reconstructive surgery solely for treatment relating to

a) teeth? ❒ Yes ❒ No

b) any other dental restoration alone? ❒ Yes ❒ No

c) cosmetic nose surgery? ❒ Yes ❒ No

Please provide copy of operation report and surgery note.

2) Name and address of the specialist who performed the surgery.

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F) This section is applicable to Cervical Spinal Cord Injury only.

1) Describe the exact nature of the cervical spinal cord injury.

(As the policy specifies that the said injury must be demonstrated by a modern scanning or imaging techniques, please **attach** a copy of the Magnetic Resonance Imaging or Computerised Tomography Scan.)

2) Has the accidental cervical spinal cord injuries resulted in the loss of use of at least one entire limb for at least 6 weeks? ❒ Yes ❒ No

If "Yes", please advise:

(i) Full details of the loss of use of the limb.

(ii) **Date of Last review** confirming the the loss of use of at least one entire limb **(**ddmmyyyy)

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G) 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** gthat 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

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 been rejected in favour of the 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 state 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 Company into 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) Computerised tomography scan (CT scan)
(ii) Magnetic resonance imaging (MRI), other imaging studies
(iii) X-Ray
(iv) Operation reports, surgical reports
(v) Referral letters (if any)
(vi) Any other investigation reports

H) 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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