



**Critical Illness Claim – Doctor’s Statement**  
**Motor Neurone Disease / Peripheral Neuropathy / Early Motor Neurone Disease**

**DOCTOR’S STATEMENT** (to be completed by the attending doctor at claimant’s expense)

<b>A) Patient’s Particulars</b>									
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>B) Patient’s Medical Records</b>									
1) Please indicate the period that is documented in the hospital/clinic’s record:									
(i) Date of <b>First</b> 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 <b>Last</b> 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? <span style="float:right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>									
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? <span style="float:right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>									
If “Yes”, please provide:									
(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? <span style="float:right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>									
(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 (e.g. tumour, diabetes, hypertension, hyperlipidaemia, hepatitis, 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: 

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(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)	<p>Is the diagnosis considered as any of the followings?</p> <p>a. Amyotrophic lateral sclerosis <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>b. Progressive bulbar palsy <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>c. Spinal muscular atrophy <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>d. Primary lateral sclerosis <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>e. Others <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>If "Yes" to (e), please state:</p>								
(viii)	Date of <b>First</b> diagnosis (ddmmyyyy) <span style="float: right;"> <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> </span>								
(ix)	Date the patient <b>First</b> became aware of the illness/condition (ddmmyyyy) <span style="float: right;"> <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> </span>								
2) Name and address of the Neurologist who <b>First</b> diagnosed the patient with the condition.									
3) Please provide full details and results of all <b>investigations</b> (with dates) performed for the diagnosis. Also, please <b>attach</b> a copy of all the relevant test reports.									
4)	<p>Is the diagnosis characterised as progressive degeneration of</p> <p>(i) Corticospinal tracts? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>(ii) Anterior horn cells? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>(iii) Bulbar efferent neurones? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>If "Yes", please elaborate with supporting evidence.</p>								

5) Please describe in full details (with dates) the extent of neurological deficit.

6) Are the neurological deficit (mentioned in Question 5):

(i) Progressive?

Yes  No

(ii) Permanent?

Yes  No

(a) If "Yes", please elaborate with supporting evidence.

(b) If "No", please state date of recovery *or* date for which the patient is likely to recover from these neurological deficits.  
(ddmmyyy)

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7) Is the diagnosis considered as peripheral motor neuropathy?

Yes  No

If "Yes", please advise:

(i) Has the peripheral motor neuropathy resulted in significant motor weakness?

Yes  No

(ii) Has the peripheral motor neuropathy resulted in fasciculation?

Yes  No

(iii) Has the peripheral motor neuropathy resulted in muscle wasting?

Yes  No

(iv) Is the peripheral motor neuropathy confirmed by nerve conduction studies?

Yes  No

If "Yes", please elaborate with supporting evidence.

(v) Has the peripheral motor neuropathy resulted in a permanent need for the use of walking aids or a wheelchair?

Yes  No

8) Is the diagnosis considered as

(i) Diabetic neuropathy?

Yes  No

(ii) Neuropathy due to Alcohol?

Yes  No

If "Yes", please elaborate with supporting evidence.

9) Please provide details of the **current treatment**.

10) 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)

11) 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:

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Date of Diagnosis of AIDS/HIV (ddmmyyy):

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

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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 (ddmmyyy)	Date the patient First became aware of the condition (ddmmyyy)	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?  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.

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 (ddmmyyy)

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If "No", please state date of discharge (ddmmyyy), 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) Computerised tomography scan (CT scan)
- (ii) Electromyogram reports
- (iii) Magnetic resonance imaging (MRI), other imaging studies
- (iv) Nerve conduction studies
- (v) X-Ray
- (vi) Operation reports, surgical reports
- (vii) Referral letters (if any)
- (viii) 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)