Critical Illness Claim - Doctor's Statement
Muscular Dystrophy / Spinal Cord Disease or Injury resulting in Bowel and Bladder Dysfunction / Moderate Muscular Dystrophy

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:

Singapore Life Ltd. • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

5) Does the patient have or ever have had any significant health conditions, medical history, or any illness (e.g. scoliosis, tumour, stroke, 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 during the **First** consultation.

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

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

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

(vi) ICD-10 Code:

Singapore Life Ltd. • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

(vii) Date of **First** Diagnosis (ddmmyyyy) ☐☐☐☐☐☐☐☐

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

2) Was the diagnosis of muscular dystrophy confirmed by muscular biopsy? ❐ Yes ❐ No

If "Yes", please advise:

Date of muscular biopsy (ddmmyyyy) ☐☐☐☐☐☐☐☐

Details of the muscular biopsy:

If "No", please advise on the clinical basis for the diagnosis of muscular dystrophy.

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 muscle biopsy, electromyogram, enzyme tests such as creatine kinase etc.

4) Name and address of the **Neurologist** who **First** diagnosed the patient with the condition.

5) Please describe in detail (with dates) the extent of neurological deficits suffered by the patient.

6) Are there signs of progressive impairment? ❐ Yes ❐ No

If "Yes", please elaborate (with dates) on how the condition has deteriorated over time.

Singapore Life Ltd. • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

7) Is the diagnosis a

(i) Spinal cord disease? ❒ Yes ❒ No

(ii) Chorda equina injury? ❒ Yes ❒ No

If "Yes", please advise:

(a) Details on the above condition.

(b) Has the above condition resulted in permanent bowel dysfunction and bladder dysfunction? ❒ Yes ❒ No

If "Yes", please advise:

(i) Is the following treatment required for the permanent bowel dysfunction and bladder dysfunction?

a) Permanent regular self-catheterisation ❒ Yes ❒ No

b) Permanent urinary conduit ❒ Yes ❒ No

(ii) Has the permanent bowel and bladder dysfunction requiring permanent regular self-catheterisation or a permanent urinary conduit lasted for at least six (6) months? ❒ Yes ❒ No

If "Yes", please advise:

Date of permanent bowel and bladder dysfunction requiring above treatment **First** started (ddmmyyyy)

8) Please provide details of current **treatment** received for Muscular Dystrophy, including the name and dosage of medication, operation contemplated (if any)?

9) 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)

Singapore Life Ltd. • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

10) 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 provide details:

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).

D) Additional Information
1) Based on the **Last consultation mentioned on Section B 1ii) above**, please **circle as applicable** in relation to the patient's ability to perform the Activities of Daily Living (ADLs), whether aided or unaided by special equipment, device and/or apparatus (and not pertaining to human aid).

Definition of ADL	Extent of Independence	Yes / No	If patient always requires another person's help, please state the followings:
Washing/Bathing: The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment. Always require another person's assistance throughout the entire activity.	**Yes / No** **Yes / No** **Yes / No**	(a) Reasons ____________________ ____________________ (b) Date of disability **First** occurred (ddmmyyyy) [ ][ ][ ][ ][ ][ ][ ][ ] (c) For how long has he/she been continuously unable to do so? ____________________
Dressing: The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment. Always require another person's assistance throughout the entire activity.	**Yes / No** **Yes / No** **Yes / No**	(a) Reasons ____________________ ____________________ (b) Date of disability **First** occurred (ddmmyyyy) [ ][ ][ ][ ][ ][ ][ ][ ] (c) For how long has he/she been continuously unable to do so? ____________________
Transferring: The ability to move from a bed to an upright chair or wheelchair and vice versa.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment. Always require another person's assistance throughout the entire activity.	**Yes / No** **Yes / No** **Yes / No**	(a) Reasons ____________________ ____________________ (b) Date of disability **First** occurred (ddmmyyyy) [ ][ ][ ][ ][ ][ ][ ][ ] (c) For how long has he/she been continuously unable to do so? ____________________

Singapore Life Ltd. • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

Mobility: The ability to move indoors from room to room on level surfaces.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment. Always require another person's assistance throughout the entire activity.	**Yes / No** **Yes / No** **Yes / No**	(a) Reasons ____________________ ____________________ (b) Date of disability **First** occurred (ddmmyyyy) [ ][ ][ ][ ][ ][ ][ ][ ] (c) For how long has he/she been continuously unable to do so? ____________________
Toileting: The ability to use the lavatory or otherwise manage bowel and bladder functions to maintain a satisfactory level of personal hygiene.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment. Always require another person's assistance throughout the entire activity.	**Yes / No** **Yes / No** **Yes / No**	(a) Reasons ____________________ ____________________ (b) Date of disability **First** occurred (ddmmyyyy) [ ][ ][ ][ ][ ][ ][ ][ ] (c) For how long has he/she been continuously unable to do so? ____________________
Feeding: The ability to feed oneself once food has been prepared and made available.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment. Always require another person's assistance throughout the entire activity.	**Yes / No** **Yes / No** **Yes / No**	(a) Reasons ____________________ ____________________ (b) Date of disability **First** occurred (ddmmyyyy) [ ][ ][ ][ ][ ][ ][ ][ ] (c) For how long has he/she been continuously unable to do so? ____________________

2) What tests or assessments were used to evaluate the patient's functional ability for each of the ADLs (e.g. standardised functional assessments, observation of patient performing ADL-specific tasks, etc.)?

Singapore Life Ltd. • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

3) If your assessment of the patient's function for each of the ADLs was taken from report(s) provided by the patient or relatives, please attach a copy of relevant report(s).

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

5) Is there anything in the patient's **lifestyle** or **personal medical history** that may have increased the patient's risk of suffering from the condition? ❒ Yes ❒ No

If "Yes", please advise:

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

6) Is there anything in the patient's **family history** that may have increased the patient's risk of suffering from the condition? ❒ Yes ❒ No

If "Yes", please advise:

Relationship with patient	Nature of condition	Age of onset	Source of information

7) 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

8) 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.

Singapore Life Ltd. • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

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

10) 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.

11) (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

12) 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

13) 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.

14) 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) Electromyography reports
- (iii) Magnetic resonance imaging (MRI), other imaging studies
- (iv) Muscular Biopsy
- (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 & Offical Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	

Singapore Life Ltd. • singlife.com
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8