* S U P D O C *

Singlife

Critical Illness Claim - Doctor's Statement
Paralysis (Irreversible Loss of Use of Limbs) / Irreversible Loss of Use of One Limb / Irreversible Loss of Use of One Limb requiring Prosthesis

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

A) Patient's Particulars

Name of Patient	Gender	Occupation

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, overweight, 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 Disability / Illness

1) Please provide details of the condition:

(i) Date of **First** consultation 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:

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

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

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

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

4) Is the diagnosis directly or indirectly, wholly or partly, caused by, or arising from or contributed to 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", please provide full details including reasons for the self-inflicted act, result of blood alcohol concentration, name of drugs, quantity consumed, diagnosis date, name of doctor and hospital/clinic where the patient was **First** diagnosed with self-inflicted act, wilful misuse of alcohol or wilful misuse of drugs.

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

5) Was the diagnosis because of an **Accident**? ❒ Yes ❒ No

If "Yes", please advise:

(i) Date of Accident (ddmmyyyy):

Time of Accident (a.m. / p.m.):

(ii) Place of Accident:

(iii) Describe in detail how the accident happened:

(iv) Describe the extent and severity of the bodily injuries/disability sustained, including exact site(s) of the body:

(v) Was the accident reported to the police? ❒ Yes ❒ No

If "No", why not?

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If "Yes", please provide the following information and **attach** a copy of the police report.

Police Division | Name of Police Officer-in-charge

(vi) 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.

6) (i) Please state the limb(s) involved and the extent of loss of use:

Specific limb	**Extent of loss of use (if applicable)**	**Is extent of loss of use above the elbow? (circle as appropriate)**	**Is extent of loss of use above the knee? (circle as appropriate)**	**Is the loss of use total and irreversible? (circle as appropriate)**
Left upper limb		Yes / No	Yes / No	Yes / No
Left lower limb		Yes / No	Yes / No	Yes / No
Right upper limb		Yes / No	Yes / No	Yes / No
Right lower limb		Yes / No	Yes / No	Yes / No

(ii) If the loss of use of the involved limb(s) is total and irreversible, please advise on the following:
The basis of the assessment: | First date of such continuous loss of use

(iii) Please advise if the paralysis or loss of use of limb(s) has persisted for at least 6 weeks? ❒ Yes ❒ No
If "Yes", please advise:

Date of initial episode (ddmmyyyy): | | | | | | | | |

(iv) Please advise if the patient underwent fitting and use of prosthesis to the affected limb(s)? ❒ Yes ❒ No

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7) Please provide your assessment of the patient's **limb power**:

Date of Assessment (ddmmyyyy)		**Limb Power**		**Limb Power**
	Left upper limb		Right upper limb	
	Left lower limb		Right lower limb	

8) Please provide your assessment of the patient's **power grip** and **precision grip**:

Date of Assessment (ddmmyyyy)		**Power Grip**	**Precision Grip**
	Left upper limb		
	Right upper limb		

9) Please provide full details and results of all **investigations and assessment reports** (with dates) performed as the basis of your evaluation to Question 6 to 8.

10) Please provide in detail the **treatment** prescribed with **dates**, including type of operation performed, rehabilitation programs (e.g. Physiotherapy – number of cycles, commencement, and termination date), medication, any surgery contemplated, etc.

11) What is the name of the doctor(s) and hospital/clinic where the patient received and/or is receiving the abovementioned treatment?

12) What was the patient's response to the treatment?

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13) Please tick in the relevant box below whether the patient's condition is likely to:

(i) Improve ❒ *or* Deteriorate ❒ *or* Remain static ❒

(ii) If "Improve", please state the extent of improvement expected and the estimated date of recovery:

(iii) If "Deteriorate" or "Remain static", please elaborate with reasons how you arrive at the opinion:

14) 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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15) 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) 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		

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

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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:

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

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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**?

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 in assessing this claim.

Please enclose copies of all investigation reports including specialist, hospital andlaboratory reports. Where applicable, please include 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

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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