



**Critical Illness Claim - Doctor's Statement**  
**Primary Pulmonary Hypertension / Early Primary or Secondary Pulmonary Hypertension**

**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, heart or asthma, 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 (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 <b>First</b> diagnosis (ddmmyyyy)	<table border="1" style="display: inline-table; border-collapse: collapse;"> <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>								
(viii)	Date the patient <b>First</b> became aware of the illness/condition (ddmmyyyy)	<table border="1" style="display: inline-table; border-collapse: collapse;"> <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>								
2) Name and address of the doctor who <b>First</b> diagnosed the patient with the condition.										
3) Is the pulmonary hypertension due to										
(i) Primary cause?	<input type="checkbox"/> Yes	<input type="checkbox"/> No								
(ii) Secondary cause?	<input type="checkbox"/> Yes	<input type="checkbox"/> No								
Please elaborate.										
4) Is the right ventricle of the heart enlarged? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>										
Please attach a copy of echocardiogram report.										
If "Yes", please advise date of <b>First</b> detection of the enlargement (ddmmyyyy)		<table border="1" style="display: inline-table; border-collapse: collapse;"> <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>								
5) Was cardiac catheterisation performed to establish the diagnosis of pulmonary hypertension? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>										
If "Yes", Please attach a copy of echocardiogram report.										
6) 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 including Chest X-ray, echocardiogram, doppler study, CT scan, ventilation-perfusion scan etc.										
7) (i) Was there permanent physical impairment that fulfill the New York Heart Association (NYHA) Classification of Cardiac Impairment? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>										
If "Yes", please advise the class of impairment according to the New York Heart Association (NYHA) Classification of Cardiac Impairment:										
Class _____										
(ii) Please describe in detail the current symptoms / permanent physical impairment.										
(iii) Is the impairment stated above likely to be permanent? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>										
If "Yes", please explain.										

8) What treatment has been administered?

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

10) Has transplantation been considered?  
If "Yes", please provide full details.

Yes  No

11) Was the patient admitted to a hospital for treatment of the diagnosis?  
If "Yes", please advise:

Yes  No

	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)
Name of the hospital				

12) 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:

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 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 have 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).

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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.

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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**?  Yes  No

If "Yes", please advise:

<u>Name of doctor and Address of hospital/clinic</u>	<u>Date of <b>First &amp; Last</b> 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 advise 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) Computerised tomography scan (CT scan)
- (ii) Dopple studies
- (iii) Echocardiogram reports
- (iv) Magnetic resonance imaging (MRI), other imaging 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)	