Critical Illness Claim - Doctor's Statement
Special Benefit - Dengue Haemorrhagic Fever

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?

(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): | | | | | | | | |

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2) Name and address of the doctor who **First** diagnosed the patient with the condition.

3) Name and address of doctor that the patient is seeing for management of his/her condition.

4) 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.

5) Is the diagnosis considered as

(i) Dengue Haemorrhagic Fever Stage 3, based on the World Health Organisation? ❒ Yes ❒ No

(ii) Dengue Haemorrhagic Fever Stage 4, based on the World Health Organisation? ❒ Yes ❒ No

(iii) Other Stages of Dengue Haemorrhagic Fever, based on the World Health Organisation? ❒ Yes ❒ No

Please provide the Stage: _____

If "Yes" to any of above, please provide the following (a) to (g).

a) Is the dengue infection confirmed by a serological testing? ❒ Yes ❒ No

If "Yes", please provide the result(s) of the serological test(s) which confirmed the diagnosis:

Type of test/assessment	Date of test/assessment	Results of test/assessment

b) Is there history of continuous high fever for two (2) or more days? ❒Yes ❒ No

If "Yes", please provide the following dates (ddmmyyyy):

From

To

c) Are there minor or major haemorrhagic manifestations? ❒Yes ❒ No

If "Yes", please provide the result(s).

d) Is there thrombocytopenia (less than or equal to 100000 per mm^3)? ❒ Yes ❒ No
If "Yes", please provide the result(s).

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e) Is there haemoconcentration (haematocrit increased by 20% or more)? ❒ Yes ❒ No

If "Yes", please provide the result(s).

f) Is there evidence of evidence of plasma leakage (i.e. pleural effusion, ascites or hypoproteinaemia, etc.)? ❒ Yes ❒ No

If "Yes", please provide details of the plasma leakage:

Type of test/assessment	Date of test/assessment	Results of test/assessment

g) Is there evidence of Dengue Shock Syndrome (DSS)? ❒ Yes ❒ No

a) Is there evidence of hypotension (less than 80 mm Hg) or narrow pulse pressure (20 mm Hg or less)? ❒ Yes ❒ No

b) Is there evidence of tissue hypoperfusion such as cold, clammy skin, oliguria, or metabolic acidosis? ❒Yes ❒ No

If "Yes", please provide details of the Dengue Shock Syndrome (DSS):

Type of test/assessment	Date of test/assessment	Results of test/assessment

Please provide the results of investigations done and attach copies of reports.

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) Is the patient's diagnosis directly or indirectly, wholly or partly caused by, arising from, 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): | | | | | | | | |

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).

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D) Other Information

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

2) 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.

3) 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.

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

5) 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.

6) a) Is the patient mentally incapacitated? ❒ Yes ❒ No

b) If the patient is mentally incapacitated, is he/she mentally capable of receiving or handling money? ❒ Yes ❒ No

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7) Are you aware of any other doctor(s), in Singapore or overseas, whom the patient consulted for the **condition or any possible related diseases**? ❒ Yes ❒ No

If "Yes", please advise:

Name of doctor and Address of hospital/clinic	Date of **First** & **Last** consultation	Reasons for consultation

8) 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. | | | | | | | | |

9) 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) Blood test reports
(ii) Computerised tomography scan (CT scan)
(iii) Magnetic resonance imaging (MRI), other imaging studies
(iv) Serological test reports
(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 & Offical Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	

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