* S U P D O C *

Singlife

Critical Illness Claim - Doctor's Statement
Stroke with Permanent Neurological Deficit / Brain Aneurysm Surgery / Cerebral Shunt Insertion / Carotid Artery Surgery

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. cyst, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, anaemia, etc.)? ❒ Yes ❒ No
If "Yes", please provide:

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

4) Please describe the initial episode:

(i) Nature of episode:

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

(iii) Duration of acute symptoms:

5) Was there any permanent neurological deficit lasting for at least six (6) weeks after the initial episode of Stroke? ❒ Yes ❒ No

If "Yes", please provide details on the permanent neurological deficit with persisting clinical symptoms which means symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the lifetime of the patient:

Please tick	**Neurological deficit**	**Date of Last review confirming the neurological deficit (ddmmyyyy)**	**Please specify the exact body parts involved**	**Is the neurological deficit permanent and expected to last throughout the lifetime?**	**Please elaborate with supporting evidence**
	Numbness			YES / NO	
	Paralysis			YES / NO	
	Localised weakness			YES / NO	
	Dysarthria (difficulty with speech)			YES / NO	
	Aphasia (inability to speak)			YES / NO	
	Dysphagia (difficulty swallowing)			YES / NO	
	Visual Impairment			YES / NO	
	Difficulty in walking			YES / NO	
	Lack of coordination			YES / NO	

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	Tremor			YES / NO	
	Seizures			YES / NO	
	Dementia			YES / NO	
	Delirium			YES / NO	
	Coma			YES / NO	
	Others, please specify:			YES / NO	

6) Has there been an infarction of brain tissue, cerebral and subarachnoid haemorrhage, intracerebral embolism and cerebral thrombosis? ❒ Yes ❒ No

If "Yes", please provide full details.

7) Are the investigations or findings consistent with the diagnosis of a new Stroke? ❒ Yes ❒ No

If "Yes", please provide details and attach a copy of all reports, CT Scan, MRI, laboratory test results, etc.

8) Please provide details of the surgery and/or other mode of treatment that had been performed, including type and date of treatment, and name and address of attending specialist.

9) Please confirm the following:

(i)	Is this a Transient Ischaemic Attack?	❒ Yes	❒ No
(ii)	Is this an attack of Vertebrobasilar ischaemia?	❒ Yes	❒ No
(iii)	Was the brain damaged due to an accident or injury?	❒ Yes	❒ No
(iv)	Was the brain damaged due to an infection?	❒ Yes	❒ No
(v)	Was the brain damaged due to a vasculities?	❒ Yes	❒ No
(vi)	Was the brain damaged due to an inflammatory disease?	❒ Yes	❒ No
(vii)	Was the condition due to vascular disease effecting the eye?	❒ Yes	❒ No
(viii)	Was the condition due to vascular disease effecting the optic nerve?	❒ Yes	❒ No
(ix)	Was the condition due to ischaemic disorder of the vestibular system?	❒ Yes	❒ No

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10) Has the patient undergone any **Brain Aneurysm Surgery**? ❒ Yes ❒ No

If "No", please proceeds to **Question 11**.

If "Yes", please advise:

(i) Was an arteriogram / cerebral angiogram carried out? ❒ Yes ❒ No

If "Yes", please advise:

(ii) Date of arteriogram performed (ddmmyyyy) | | | | | | | | |

Please attach a copy of the report.

(iii) Was surgery carried out to correct

a) intracranial aneurysm? ❒ Yes ❒ No

b) arterio-venous malformation of one (1) or more of the cerebral arteries? ❒ Yes ❒ No

(iv) Date of surgery (ddmmyyy) | | | | | | | | |

(v) Nature of surgery

(vi) Was surgery done via endovascular? ❒ Yes ❒ No

If "No", please state the type of surgery performed.

(vii) Was surgery done via craniotomy? ❒ Yes ❒ No

If "No", please state the type of surgery performed.

(viii) Was surgery done via Gamma Knife radiosurgery? ❒ Yes ❒ No

If "No", please state the type of surgery performed.

(ix) Was the surgery performed certified to be absolutely necessary by a neurosurgeon/neurologist? ❒ Yes ❒ No

Please attach a copy of the tomography (CT) scan, magnetic resonance imagin (MRI), magnetic resonance angiograph (MRA) or angiogram.

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11) Has the patient undergone any **Cerebral Shunt Insertion**? ❒ Yes ❒ No
If "No", please proceeds to **Question 12**.
If "Yes", please advise:

(i) How was this diagnosis established?
Please include a copy of diagnostic investigation report.

(ii) Is the patient's condition of hydrocephalus congenital in nature? ❒ Yes ❒ No
If "No", please indicate the cause of hydrocephalus.

(iii) Was there any intracranial pressure giving rise to neurological deficit as a result of hydrocephalus? ❒ Yes ❒ No
If "Yes", please indicate the neurological deficit(s).

(iv) Was there surgical implantation of a shunt from the ventricles of the brain? ❒ Yes ❒ No
If "Yes", please advise:

a) Date of shunt insertion (ddmmyyyy) | | | | | | | | |

(v) Was the surgical implantation of a shunt from the ventricles of the brain to relieve raised pressure in the cerebrospinal fluid? ❒ Yes ❒ No

(vi) Was the surgery performed considered medically necessary by the consultant neurosurgeon? ❒ Yes ❒ No

(vii) Is there other mode of treatment other than shunt insertion, which could have been used to treat the patient's hydrocephalus? ❒ Yes ❒ No
If "Yes", please state the nature of treatment and why this treatment was not used.

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12) Did the patient suffer from **narrowing of the Carotid Artery**? ❒ Yes ❒ No
If "No", please proceeds to **Section D**.
If "Yes", please advise:

(i) Was an arteriography carried out? ❒ Yes ❒ No
If "Yes", please provide a copy of report.

(ii) Please state the percentage of narrowing of the carotid artery. ____ %

(iii) Was Endarterectomy carried out to correct the carotid artery? ❒ Yes ❒ No

If "Yes", please state the date of surgery (ddmmyyyy) | | | | | | | | |

If "No", please state the type of treatment provided.

(iv) Was Endarterectomy of blood vessels other than the carotid artery done? ❒ Yes ❒ No

D) Other Information

1) 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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2) Is the patient's diagnosis or surgery 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)								
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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3) What is the prognosis of the patient's condition?

4) Is there anything in the patient's **lifestyle** or **personal medical history** 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

5) Is there anything in the patient's **family history** which 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

6) 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.

7) 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.

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

9) 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.

10) (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

11) 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

12) 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.

13) 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) 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

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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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