



Critical Illness Claim - Doctor's Statement Severe Encephalitis / Encephalitis

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) <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) Patient's Medical Records									
1) Please indicate the period that is documented in the hospital/clinic's record:									
(i) Date of First 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 Last 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? <input type="checkbox"/> Yes <input type="checkbox"/> No									
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? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If "Yes", please advise:									
(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? <input type="checkbox"/> Yes <input type="checkbox"/> No									
(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, 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 provide details of the patient's **smoking** habit(s), 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 provide 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 **First** diagnosis (ddmmyyyy):

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

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2) Is the Encephalitis caused by viral infection?

Yes No

If "No", please indicate the underlying cause of the condition.

If "Yes", was any appropriate investigation (including Lumbar puncture test) performed to prove the acute viral infection of the brain?

Yes No

Please describe in full details (with dates) of the investigations performed.

Date of investigations (ddmmyyyy)	Types of investigations performed	Details of investigations

Please **attach** a copy of all relevant test reports.

3) Is there any severe inflammation of the brain substance (cerebral hemisphere, brainstem, or cerebellum)?

Yes No

If "Yes", was any appropriate investigation (including Lumbar puncture test) performed to prove the severe inflammation of the brain substance (cerebral hemisphere, brainstem, or cerebellum)?

Yes No

Please describe in full details (with dates) of the investigations performed.

Date of investigations (ddmmyyyy)	Types of investigations performed	Details of investigations

Please **attach** a copy of all relevant test reports.

4) Please describe in full details (with dates) the extent of neurological deficits.

Date of initial episode (ddmmyyyy)	Types of neurological deficits experienced	Duration of symptoms

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

If "Yes", please provide details on the permanent neurological deficit with persisting clinical symptoms which indicates 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 part(s) affected	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	
	Tremor			Yes / No	
	Seizures			Yes / No	
	Dementia			Yes / No	
	Delirium			Yes / No	
	Coma			Yes / No	
	Others, please specify:			Yes / No	

6) Please provide full details and results of all **investigation** (with dates) performed for the diagnosis. Also, please **attach** a copy of all the relevant test reports including **Brain MRI, culture of cerebrospinal fluid (CSF), electroencephalogram etc.**

7) Name and address of the **neurologist** who **First** diagnosed the patient with the condition:

8) Please provide details of ongoing **treatment**, including any physical and/or speech therapy, 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)	
	Admission Date (ddmmyyyy)	Discharge Date (ddmmyyyy)	Admission to ICU (ddmmyyyy)	Discharge from ICU (ddmmyyyy)

10) Is the diagnosis directly or indirectly, wholly or partly caused by, arising from, or contributed by any of the following?

(i) Human Immunodeficiency Virus (HIV) infection?

Yes No

(ii) 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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Name and Address of doctor who **First** diagnosed the patient

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

11) Is the patient's diagnosis directly or indirectly, wholly or partly caused by, arising from, or contributed to by any of the following?

(i) Wilful misuse of alcohol?

Yes No

(ii) Wilful misuse of drugs?

Yes No

(iii) 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
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 the 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 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 relevant details forming 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

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 First & Last consultation</u>	<u>Reasons for consultation</u>

10) Is the patient still on follow-up at your hospital/clinic? Yes No

If "Yes", please state date of next appointment (ddmmyyy):

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If "No", please state date of discharge (ddmmyyy), 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 include the following:

- (i) Blood test reports
- (ii) Cerebrospinal fluid analysis result reports
- (iii) Computerised tomography scan (CT scan)
- (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)	