



**Critical Illness Claim - Doctor's Statement
Benign Brain Tumour /
Surgical Removal of Pituitary Tumour / Surgery for Subdural Haematoma**

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. cyst, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, anaemia, etc) If "Yes", please advise: <u>Details of symptoms</u> <u>Exact diagnosis</u> <u>Date diagnosed</u> <u>Treatment</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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 past and present smoking habits, including the duration of smoking habit(s), number of cigarettes smoked per day and source of this information. <u>No. of years of smoking</u> <u>No. of sticks per day</u> <u>Source of information</u>	
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. <u>Type of alcohol</u> <u>Quantity per Consumption</u> <u>Frequency (per week / month, etc)</u> <u>Source of information</u>	

C) Details of Illness

1) Please provide details of the condition:											
(i) Date of First consultation for the condition (ddmmyyy):	<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> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
(ii) Details of symptom(s) presented during the First consultation:											
(iii) Date of onset of these symptoms (ddmmyyy):	<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> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
(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 (ddmmyyy):	<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> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
(viii) Date the patient First became aware of the illness/condition (ddmmyyy):	<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> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										

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) Is the tumour a non-malignant tumour? Yes No
 If "Yes", please advise:

(i) Is the Tumour located in the cranial vault? Yes No

(ii) Is the Tumour located in the brain? Yes No

(iii) Is the Tumour located in the meninges? Yes No

(iv) Is the Tumour located in the cranial nerves? Yes No

If you responded "No" to questions i) to iv), kindly indicate the area affected:

5) Please advise on the following questions regarding the **Benign Brain tumour**.
 (If you've responded "**Yes**" to any question, please supplement with supporting documents including magnetic resonance imaging, computerised tomography, or any other reliable imaging techniques.)

(i) Is it life threatening? Yes No

(ii) Has it caused damage to the brain? Yes No

(iii) Has it been surgically removed? Yes No

(a) Type of Surgery:

(b) Date of Surgery (ddmmyyyy):

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(c) Tumour has been totally or partially removed? (Please tick) Totally removed Partially removed

(d) Details of histology:

(iv) If the tumour is inoperable, has it caused any neurological deficits? Yes No
 If "Yes", please advise:

(a) Details of the neurological deficits suffered:

(b) Are the neurological deficits permanent? Yes No

(v) Is the diagnosis supported by Magnetic Resonance Imaging, Computerised Tomography, or any other reliable imaging techniques? Yes No
 If "Yes", please provide details for the above:

- 6) Is the patient's condition
- (i) A cyst? Yes No
 - (ii) An abscess? Yes No
 - (iii) An angioma? Yes No
 - (iv) A granuloma? Yes No
 - (v) A vascular malformation of the arteries or veins of the brain? Yes No
 - (vi) A haematoma? Yes No
 - (vii) A tumour of the pituitary gland? Yes No
 - (viii) A tumour of the spinal cord? Yes No
 - (ix) A tumour of the skull base? Yes No

7) Has the patient undergone **surgery for Removal of Pituitary Tumour**? Yes No

If "No", please proceed to **Question 8**.

If "Yes", please advise on the following:

- (i) What were the investigations done to establish the diagnosis of Pituitary tumour? Please provide a copy of diagnostic reports (i.e. Magnetic Resonance Imaging (MRI), Computerised Tomography (CT) or others.)

- (ii) Is the patient's condition a pituitary microadenoma? Yes No

If "Yes", is the tumour of size 1cm or below in diameter?

Yes No

Please advise on the size of the tumour:

- (iii) Has the tumour caused an increase in the intracranial pressure? Yes No

- (iv) Is the undergoing of surgical removal of pituitary tumour necessitated because of symptoms associated with increased intracranial pressure caused by the tumour? Yes No

(v) Date of Surgery (ddmmyyyy):

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- (vi) Is the surgery a partial removal of pituitary microadenoma? Yes No

8) Has the patient undergone **surgery for Subdural Hematoma**? Yes No

If "No", please proceed to **Section D**.

If "Yes", please advise on the following:

(i) Was the cause of subdural hematoma a result of an accident? Yes No

If "Yes", please provide Date of Accident
(ddmmyyyy):

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Please provide details of how the accident occurred:

(ii) What were the investigations done to establish the diagnosis of subdural Hematoma? Please provide a copy of diagnostic reports (i.e. Magnetic Resonance Imaging (MRI), Computerised Tomography (CT) or others.):

(iii) Was the subdural hematoma drained through a Burr Hole Surgery to the head? Yes No

If "No", please indicate the treatment provided:

D) Other Information

1) Was the patient admitted to a hospital for treatment of the diagnosis? Yes No

If "Yes", please advise:

Name of the hospital		
Admission Date and Time (ddmmyyyy; hh:mm)		
Discharge Date and Time (ddmmyyyy; hh:mm)		
Name of the hospital		
Admission Date and Time (ddmmyyyy; hh:mm)		
Discharge Date and Time (ddmmyyyy; hh:mm)		

2) Was the patient admitted to Intensive Care Unit (ICU) for treatment of the diagnosis? Yes No
 If "Yes", please advise:

Name of the hospital		
Admission Date and Time (ddmmyyyy; hh:mm)		
Discharge Date and Time (ddmmyyyy; hh:mm)		
Name of the hospital		
Admission Date and Time (ddmmyyyy; hh:mm)		
Discharge Date and Time (ddmmyyyy; hh:mm)		

3) 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", please provide full details including reasons for the 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 HIV or AIDS, wilful misuse of alcohol, wilful misuse of drugs or congenital anomaly or defect.

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

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

5)	Is there anything in the patient's lifestyle or personal medical history that may have increased the risk of the condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", please advise: <u>Type of Lifestyle / Exact diagnosis</u> <u>Date of diagnosis</u> <u>Name of doctor & address of hospital/clinic</u>		
6)	Is there anything in the patient's family history that may have increased the risk of the condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", please advise: <u>Relationship with patient</u> <u>Nature of condition</u> <u>Age of onset</u> <u>Source of information</u>		
7)	Have active treatment and therapy been rejected in favour of the relief of symptoms? If "Yes", please provide full details and explain the reason for this course of action.	<input type="checkbox"/> Yes <input type="checkbox"/> No
8)	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? (ii) Twelve (12) months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 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 the basis of your evaluation:		
9)	Please describe and elaborate on the nature and severity of the patient's physical disability and limitation(s).	
10)	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.	
11)	(i) Is the patient mentally incapacitated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	(ii) If the patient is mentally incapacitated, is he/she mentally capable of receiving or handling money?	<input type="checkbox"/> Yes <input type="checkbox"/> No

12) 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

13) Is the patient still on follow-up at your hospital/clinic? Yes No
 If "Yes", please advise date of next appointment (ddmmyyy):

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 If "No", please state date of discharge (ddmmyyy), if any:

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14) 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) Biopsy reports, cytology reports, histopathology reports
- (ii) Computerised tomography scan (CT scan)
- (iii) Magnetic resonance imaging (MRI), other imaging studies
- (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 & Official Stamp of Doctor
Name of Doctor	
Date (ddmmyyy)	