



Critical Illness Claim - Doctor's Statement
End Stage Liver Failure / Liver Surgery / Liver Cirrhosis

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 Reasons 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:

<u>Details of symptoms</u>	<u>Exact diagnosis</u>	<u>Date diagnosed</u>	<u>Treatment</u>

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.

<u>No. of years of smoking</u>	<u>No. of sticks per day</u>	<u>Source of information</u>

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.

<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:
Date the patient **First** consulted you for the condition (ddmmyyy)

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(i) Details of symptom(s) presented at **First** consultation.

(ii) Date of onset of these symptoms (ddmmyyy)

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(iii) What is/are the underlying cause(s) of the symptoms?

(iv) **Final** Diagnosis of the condition:

(v) ICD-10 Code:

(vi) Date of First diagnosis (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>								
(vii) Date the patient First became aware of the illness/condition (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>								
2) Name and address of the doctor who First diagnosed the patient with the condition:									
3) Is the patient diagnosed of end stage liver failure? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If "Yes", please advise:									
i) Date of First diagnosis (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) Child-Pugh Score for the diagnosis of end stage liver failure with a copy of laboratory evidence submitted.									
4) Is there evidence of jaundice? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If "Yes", please advise:									
(i) Date of First detection (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) Would the jaundice be permanent?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
5) Is there evidence of ascites? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If "Yes", please advise:									
(i) Date of First detection (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) Mode of detection (e.g. clinical, paracentesis, ultrasound):									
(iii) Underlying causes:									
(iv) Complications (if any):									
(v) Treatment:									

6) Is there evidence of hepatic encephalopathy? Yes No

If "Yes", please advise:

(i) Date of **First** detection (ddmmyyyy)

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(ii) Underlying causes:

(iii) Complications (if any):

(iv) Treatment:

7) Was there partial hepatectomy of at least one entire lobe of the liver? Yes No

If "Yes", please advise:

(i) Date of surgery (ddmmyyyy)

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(ii) Reason(s) for requiring hepatectomy:

(iii) Was partial hepatectomy medically necessary?

Yes No

If "Yes", please support with evidence.

(IV) Was the patient a donor who underwent hepatectomy?

Yes No

8) Is there evidence of liver cirrhosis? Yes No

If "Yes", please advise:

(i) HAI-Knodell score with a copy of the liver biopsy report submitted.

(ii) Name of Hepatologist and address of hospital who diagnosed the liver cirrhosis.

9) Is the liver disease suffered by the patient secondary to:

(i) Alcohol abuse?

Yes No

(ii) Drug abuse?

Yes No

If "Yes" for any of the above, 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 Alcohol abuse or Drug abuse.

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

10) Is there evidence of bleeding from the oesophageal varices?

Yes No

If "Yes", please advise:

(i) Episodes of bleeding, including date and treatment.

(ii) Was there endoscopy and/or radiological evidence of oesophageal varices?

Yes No

If "Yes", please attach a copy of the report.

11) 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 including biopsy and serology reports, paracentesis and ultrasound reports, a serial of liver function test results with Gamma GT and Bilirubin levels, etc.

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

13) 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)		

14) 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)		

15) 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:

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Date of Diagnosis of AIDS/HIV (ddmmyyy):

Date the patient **First** became aware of the condition: (ddmmyyy):

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(ii) congenital anomaly or defect?

Yes No

If "Yes", please provide full details including diagnosis date, name of doctor and Hospital/Clinic who **First** diagnosed the patient with HIV or AIDS or congenital anomaly or defect.

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 th 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 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?
If "Yes", please provide full details why this view / course of action is taken. Yes No

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 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).

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

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</u>	<u>Date of First & Last consultation</u>	<u>Reasons for consultation</u>
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10) Is the patient still on follow-up at your hospital / clinic?
If "Yes", please advise date of next appointment (ddmmyyyy)

Yes No

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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 that are available. Where applicable, please include the following:

- (i) Biopsy reports
- (ii) Blood test reports
- (iii) Computerised tomography scan (CT scan)
- (iv) Magnetic resonance imaging (MRI), other imaging studies
- (v) Ultrasound & radiology reports
- (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 (ddmmyyyy)