Critical Illness Claim - Doctor's Statement
End Stage Lung Disease / Severe Asthma / Insertion of a Vena-cava filter / Surgical Removal of Lung

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, asthma, chronic cough, 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:

Date the patient **First** consulted you for the condition (ddmmyyyy) ☐☐☐☐☐☐☐☐

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

(ii) Date of onset of these symptoms (ddmmyyyy) ☐☐☐☐☐☐☐☐

(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) ☐☐☐☐☐☐☐☐

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(vii) Date the patient **First** became aware of the illness/condition (ddmmyyyy) ☐☐☐☐☐☐☐☐

2) Name and address of the Respiratory specialist who **First** diagnosed the patient with the condition:

3) Please advise:

(i) The patient's lung disease condition.

(ii) Has the lung disease reached end stage? ❒ Yes ❒ No

If "Yes", please state date of End Stage Lung Disease (ddmmyyyy) ☐☐☐☐☐☐☐☐

4) 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 pulmonary function tests (especially current FEV1 and vital capacity readings) etc.

5) Is there laboratory evidence that shows FEV_1 test results which are consistently less than one (1) litre? ❒ Yes ❒ No

6) Does the patient require extensive and permanent oxygen therapy for hypoxemia? ❒ Yes ❒ No

If "Yes", please advise:

(i) Date of commencement (ddmmyyyyy) ☐☐☐☐☐☐☐☐

(ii) Frequency:

(iii) Place where oxygen therapy is administered:

7) Is there dyspnea at rest? ❒ Yes ❒ No
If "Yes", please describe the severity and start date of symptoms, treatment, and explain on how this restricts daily activities.

8) Is the patient's arterial blood gas analysis with partial oxygen pressures less than 55mmHg (i.e. $PaO2 < 55mmHg$)? ❒ Yes ❒ No

If "Yes", please provide full details of all arterial blood gas analysis results.

If "No", please give the actual readings.

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9) Did the patient undergo **Pneumonectomy** (complete surgical removal of a lung)? ❒ Yes ❒ No

If "No", please proceed to **Question 10**.

If "Yes", please advise:

(i) Date of surgery (ddmmyyyy)

(ii) Was the surgery performed considered medically necessary? ❒ Yes ❒ No

(iii) Reason(s) for requiring Pneumonectomy:

(iv) Attach a copy of surgery and histology report.

10) Is the patient suffering or has the patient suffered from **Severe Asthma** condition? ❒ Yes ❒ No

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

If "Yes", please advise:

(i) Was there evidence of an acute attack of Severe Asthma with persistent status asthmaticus? ❒ Yes ❒ No

If "Yes", please provide full details including the severity of the condition.

(ii) Was the patient hospitalised and required assisted ventilation with a mechanical ventilator? ❒ Yes ❒ No

If "Yes", please advise:

(a) Date of admission (ddmmyyyyy)

(b) Date of discharge (ddmmyyyyy)

(c) How many hours was the patient on mechanical ventilator? ________ **Hours**

(d) Was the stated period continuous? ❒ Yes ❒ No

(e) Is the patient on continuous daily usage of oral corticosteriods to control asthma? ❒ Yes ❒ No

If "Yes", for how long has the patient been on oral corticosteriods? ________ **Hours**

If "No", date of **Last** consumption of oral corticosteroids (ddmmyyyy)

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11) Is the patient suffering or has the patient suffered from **Pulmonary Emboli**? ❐ Yes ❐ No

If "Yes", please advise:

(i) Date when the patient **First** consulted you for pulmonary emboli (ddmmyyyy)

(ii) Date of any subsequent pulmonary embolism. Please provide dates of every recurrence:

Date Consulted	Reason for Consultation	Treatment Provided	Patient's Response	Name & Address of Doctor

(iii) Was there surgical insertion of vena-cava filter? If "Yes", please state: ❐ Yes ❐ No

(a) Date of Surgery (ddmmyyyy)

(b) Was the surgery performed considered medically necessary by the consultant cardiologist? ❐ Yes ❐ No

(c) Is there other alternate treatment which could also treat the patient's condition? ❐ Yes ❐ No

If "Yes", please state the type of treatment.

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

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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)		

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3) 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 state date HIV/AIDS was diagnosed (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”, 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) Has the patient ever been exposed to any substance that is likely to increase the risk of lung disease (e.g. exposure throug occupation or residential, etc.)? ❒ Yes ❒ No

If “Yes”, please provide full details.

6) 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

7) 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

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8) 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.

9) 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.

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

11) 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.

12) 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

13) 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

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

If “Yes”, please advise date of next appointment (ddmmyyyy)

If “No”, please state date of discharge (ddmmyyyy), if any.

15) 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) Arterial blood gas reports
(ii) Blood test reports
(iii) Computerised tomography scan (CT scan)
(iv) Lung histology reports
(v) Magnetic resonance imaging (MRI), other imaging studies
(vi) Serial pulmonary function tests reports
(vii) Spirometry With FEV1 Measurement reports
(viii) Ultrasound & radiological reports
(ix) Operation reports, surgical reports
(x) Referral letters (if any)
(xi) 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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