



**Critical Illness Claim - Doctor's Statement**  
**Heart Attack / Cardiomyopathy / Pericardial Disease / Cardiac Arrhythmia**

**SECTION 2 – DOCTOR'S STATEMENT** (to be completed by the attending doctor at claimant's expense)

<b>A) Patient's Particulars</b>									
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>B) Patient's Medical Records</b>									
1) Please state over what period does the Hospital/Clinic's record extend?									
(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? <span style="float:right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>									
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? <span style="float:right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>									
If "Yes", please provide:									
(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 the patient was referred:									
(iii) Name and address of doctor recommending the referral:									
If "No", how did the patient come to consult at your hospital/clinic? (e.g. A&E.)									
4) Have you referred the patient to any other doctor? <span style="float:right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>									
(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. hyperlipidaemia, hypertension, angina, hepatitis, diabetes, tumour, etc.)? If "Yes", please provide: <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 give details of the patient's habits in relation to past and present <b>smoking</b> , 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 habits in relation to <b>alcohol consumption</b> , 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>	

<b>C) Details of Illness</b>											
1) Please provide details of <b>Heart Attack</b> :											
(i) Date of first consultation for this 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 at 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 the underlying cause(s) of the symptoms?											
(v) Exact Diagnosis of the condition:  ICD-10 Code (if applicable):											
(vi) 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>										
(vii) 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>										



8) Please advise with regard to the left ventricular ejection fraction:

(i) Was there left ventricular ejection fraction of less than 50% measured three months or more after the event?  Yes  No

(ii) What was the left ventricular ejection fraction at initial diagnosis?

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9) Was there death of a portion of the heart muscle?  Yes  No  
If "Yes", please provide details.

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10) Was there imaging evidence of new loss of viable myocardium or new regional wall motion abnormality?  Yes  No  
If "Yes", please elaborate with supporting evidence of imaging reports and name of the attending cardiologist.

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

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12) Date of return to normal activities (ddmmyyyy) 

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13) Has the patient suffered from **Cardiomyopathy** condition?  Yes  No  
If "No", please proceed to **Question 14**.  
If "Yes", please proceed as follows:

(i) Date of first diagnosis of Cardiomyopathy (ddmmyyyy) 

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(ii) Has the patient previously undergone any cardiac investigation (e.g. ECG, echocardiogram, CT scan, etc.)?  Yes  No  
If "Yes", please advise:

(a) Type of cardiac investigation done:

(b) Date of investigation (ddmmyyyy) 

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Please **attach** a copy of the above investigation reports.

(iii) Was the diagnosis of cardiomyopathy made unequivocally by cardiac echocardiogram?  Yes  No  
If "Yes", please attach a copy of the echocardiogram report.  
If "No", please specify the basis of diagnosis.

(iv) Does the patient have any cardiac or physical impairment which fulfills the New York Heart Association (NYHA) Classification of Cardiac Impairment criteria?  Yes  No

If "Yes", please describe the patient's current symptoms.

Please state the NYHA class of impairment? (delete as appropriate):

**Class I / II / III / IV**

(v) Is the patient's cardiomyopathy condition related to:

(a) Alcohol misuse?  Yes  No

(b) Drug misuse?  Yes  No

If "Yes", please provide details of alcohol/drug consumption, including the amount, frequency and types of consumption.

14) Has the patient suffered from **Pericardial disease** condition?  Yes  No

If "No", please proceed to **Question 15**.

If "Yes", please advise the following:

(i) Date of first diagnosis of Pericardial disease (ddmmyyyy)

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(ii) Was surgery performed for the patient's pericardial disease condition?  Yes  No

If "Yes", please advise:

(a) Type of surgery performed (e.g. pericardectomy, keyhole cardiac surgery, etc.):

(b) Date of surgery (ddmmyyyy)

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Please **attach** a copy of the above investigation reports.

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

(iv) Was there any other mode of treatment other than the above surgery that could have been performed?  Yes  No

If "Yes", please specify:

(a) Alternate mode of treatment.

(b) Reasons why the above alternate mode of treatment was not used.

15) Has the patient suffered from **Cardiac Arrhythmia**?

Yes  No

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

If "Yes", please attach a copy of the ECG tracing and advise:

(i) Type of cardiac arrhythmia presented:

(ii) Date of first diagnosis (ddmmyyyy)

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(iii) Was pathway ablation therapy attempted?

Yes  No

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

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If "No", why was this not done?

(iv) Was a permanent cardiac pacemaker inserted?

Yes  No

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

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(v) Was a permanent cardiac defibrillator inserted?

Yes  No

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

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(vi) Was there any other mode of treatment which could have been used to treat the patient's cardiac arrhythmia? If "Yes", please specify:

Yes  No

(a) Alternate mode of treatment.

(b) Reasons why the above alternate mode of treatment was not used.

#### D) Other Information

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

2) Has the patient **previously** had any cardiac investigation done (e.g. ECG, echocardiogram, CT scan)?

Yes  No

If "Yes", please provide details:

(i) Type, results and date of cardiac investigation done:

(ii) Reasons for the investigation:

(iii) Name of cardiologist and address of hospital / clinic:

3) Is there anything in the patient's **personal medical history** which would have increased the risk of heart diseases?  Yes  No

If "Yes", please provide details:

Exact diagnosis Date of diagnosis Name of doctor & address of hospital/clinic

4) Is there anything in the patient's **family history** which would have increased the risk of Heart disease?  Yes  No

If "Yes", please give details:

Relationship with patient Nature of condition Age of onset Source of information

5) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for **Heart Attack** or any other related diseases?  Yes  No

If "Yes", please give details:

Name of doctor and address of hospital/clinic Date of first & last consultation Reasons for consultation

6) Please provide us with any other additional information that will enable the Company to assess this claim.

7) Please enclose a copy of all investigations reports including specialist or hospital reports (e.g. cardiac enzyme assays, exercise stress tests, coronary angiography, echocardiography, myocardial perfusion scans, etc.) that are available.

**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)	