* S U P D O C *

Singlife

Critical Illness Claim - Doctor's Statement
Major Head Trauma / Facial Reconstructive Surgery / Cervical Spinal Cord Injury / Intermediate Stage Major Head Trauma

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 state over what period does the Hospital/Clinic's record extend?

(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 Reasons 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 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? ❒ 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, 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 habits in relation to past and present **smoking**, 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 habits in relation to **alcohol consumption**, 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 (ddmmyyyy) | | | | | | | | |

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

(iii) Date of onset of these symptoms (ddmmyyyy) | | | | | | | | |

(iv) What is the underlying cause(s) of the symptoms?

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

ICD-10 Code (if applicable):

(vi) Date of **First** diagnosis (ddmmyyyy) | | | | | | | | |

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

2) Please provide full details and results of all **investigation** performed (with dates) performed for the diagnosis. Also, please **attach** a copy of all the relevant test reports.

3) Name and address of the doctor who **First** diagnosed the patient with the diagnosis.

4) Is the diagnosis because of an **Accident**? ❒ Yes ❒ No

If "Yes", please advise:

(i) Date of Accident (ddmmyyyy) | | | | | | | | |

(ii) Time of Accident _____ a.m. / p.m.

(iii) Place of Accident:

(iv) Describe in detail how the accident happened.

(v) Describe the extent and severity of the brain, facial, spinal cord and/or bodily injuries/disability sustained, including exact site(s) of the body.

(vi) Was the accident reported to the police? ❒ Yes ❒ No

If "No", why not?

If "Yes", please provide the following information and **attach** a copy of the police report.

Police Division Name of Police Officer-in-charge

(vii) Did the patient have any medical condition(s) that had contributed to the accident (e.g. fits) ❒ Yes ❒ No

If "Yes", please provide full details.

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(vii) Did the patient have any medical condition(s) that had contributed to the accident (e.g. fits) ❒ Yes ❒ No

If "Yes", please provide full details.

5) Is the diagnosis directly or indirectly, wholly, or partly caused by or arising from or contributed to by

(i) self-inflicted act? ❒ Yes ❒ No

(ii) wilful misuse of alcohol? ❒Yes ❒ No

(iii) wilful misuse of drugs? ❒ Yes ❒ No

If "Yes", please provide full details including reasons for the self-inflicted act, result of blood alcohol concentration, name of drugs, quantity consumed, diagnosis date, name of doctor and Hospital/Clinic who **First** diagnosed the patient with self-inflicted act, wilful misuse of alcohol or wilful misuse of drugs.

Please provide copy of test result.

6) Was the patient hospitalised for the condition or its related symptoms or complications? ❒ Yes ❒ No

If "Yes", please advise.

Date of hospitalisation	Reasons for hospitalisation	Treatment received (including operation, if any)	Name of doctor/surgeon & Address of hospital

7) Did the patient refuse any form of medical treatment, including surgery, which might have prevented or reduced the severity of the impairment? ❒ Yes ❒ No

If "Yes", please provide full details.

8) If the patient had suffered from

(i) Major Head Trauma, please proceed to **Section D.**

(ii) Facial Injury, proceed to **Section E**.

(iii) Cervical Spinal Cord Injury, proceed to **Section F**.

D) This section is applicable for Major Head Trauma only.

1) Describe the exact nature of the brain injury.

(As the policy specifies that the brain injury must be demonstrated by a modern scanning or imaging techniques, please **attach** a copy of the Magnetic Resonance Imaging or Computerised Tomography Scan.)

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2) Was the patient diagnosed of:

(i) head injury? ❒ Yes ❒ No

(ii) spinal cord injury? ❒ Yes ❒ No

(iii) head injury due to other cause? ❒ Yes ❒ No

If yes, please advise the cause:

3) Was there any form of neurological deficit still present 6 weeks after the date of the accident? ❒ Yes ❒ No

If "Yes", please advise:

(i) Full details of the neurological deficits.

(ii) **Date of Last review** confirming the neurological deficit **(**ddmmyyyy)

4) Is the neurological deficit permanent and expected to last throughout the lifetime of the patient? ❒ Yes ❒ No

If "No", please state the date of recovery *or* date for which the patient is expected to recover from the neurological deficit (ddmmyyyy)

If "Yes", please support with evidence.

5) Name and address of the neurologist who **First** diagnosed the patient with Major Head Trauma.

6) Was there any surgery done? ❒ Yes ❒ No

If "Yes", please advise:

(i) Date of surgery (ddmmyyyy)

(ii) Nature or type of the surgery performed (e.g. open craniotomy,burr hole surgery, etc.)

Please provide copy of operation report and surgery note.

(iii) If the patient undergone open craniotomy, was it due to consequence of major head trauma for the treatment of depressed skull fractures or major intracranial injury? ❒ Yes ❒ No

(iv) Did the patient undergo burr hole surgery? ❒ Yes ❒ No

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7) Please provide details of current **treatment**, including any physical and speech therapy, if any.

E) This section is applicable to Facial Reconstructive Surgery only.

1) Was there any reconstructive surgery above the neck (restoration or reconstruction of the shape of, and appearance of facial structures which were defective, missing or damaged or misshapen) to correct disfigurement as a direct result of the accident? ❒ Yes ❒ No

If "Yes", please advise:

(i) Date of surgery performed (ddmmyyyy) | | | | | | | | |

(ii) Was the reconstructive surgery solely for treatment relating to

a) teeth? ❒ Yes ❒ No

b) any other dental restoration alone? ❒ Yes ❒ No

c) cosmetic nose surgery? ❒ Yes ❒ No

2) Name and address of the specialist who performed the surgery.

F) This section is applicable to Cervical Spinal Cord Injury only.

1) Describe the exact nature of the cervical spinal cord injury.

(As the policy specifies that the said injury must be demonstrated by a modern scanning or imaging techniques, please **attach** a copy of the Magnetic Resonance Imaging or Computerised Tomography Scan.)

2) Has the accidental cervical spinal cord injuries resulted in the loss of use of at least one entire limb for at least 6 weeks? ❒ Yes ❒ No

If "Yes", please advise:

(i) Full details of the loss of use of the limb.

(ii) **Date of Last review** confirming the the loss of use of at least one entire limb **(**ddmmyyyy) | | | | | | | | |

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G) Other Information

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

2) Has the patient previously suffered from the conditions leading to the diagnosis? ❒ Yes ❒ No

If "Yes", please provide details including diagnosed date, exact diagnosis, treatment prescribed, name and address of attending doctor.

3) Is there anything in the patient's **lifestyle** or **personal medical history** which would 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

4) Is there anything in the patient's **family history** which would 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

5) Has active treatment and therapy now been rejected in favour of relief of symptoms? ❒ Yes ❒ No
If "Yes", please provide full details why this view / course of action is taken.

6) 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.

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

8) Please describe and elaborate on the nature and severity of the patient's **mental** disability and limitations, including the degree of cognitive and/or intellectual impairment.

9) (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

10) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for the **condition or any possible related illness**, especially any consultations concerning neruological symptoms or complaints? ❒ Yes ❒ No
If "Yes", please advise:

Name of doctor and Address of hospital/clinic	Date of **First** & **Last** consultation	Reasons for consultation

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

12) Please enclose a copy of all investigation reports including specialist reports, hospital reports, laboratory reports and etc that are available.

(i) Computerised tomography scan (CT scan)
(ii) Magnetic resonance imaging (MRI), other imaging studies
(iii) X-Ray
(iv) Operation reports, surgical reports
(v) Referral letters (if any)
(vi) Any other investigation reports

H) 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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