



### Critical Illness Claim - Doctor's Statement Multiple Sclerosis

**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. cyst, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, frequent falls, etc.) If "Yes", please provide:	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; border-bottom: 1px solid black;"><u>Details of symptoms</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Exact diagnosis</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Date diagnosed</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Treatment</u></td> </tr> </table>	<u>Details of symptoms</u>	<u>Exact diagnosis</u>	<u>Date diagnosed</u>	<u>Treatment</u>	
<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 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>		

**C) Details of Illness**

1) Please provide details of <b>Multiple Sclerosis</b> :									
(i) Date the patient First consulted you for this condition (ddmmyyy)	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>								
(ii) Details of symptom(s) presented at first consultation, and date these symptoms First started.									
(iii) What is the underlying cause(s) of the symptoms?									
(iv) Exact Diagnosis of the condition:									
ICD-10 Code (if applicable):									

(v) Date of <b>First</b> 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> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
(vi) Date the patient <b>First</b> 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> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
2) Please provide details of <b>investigation</b> performed (with dates) to establish the unequivocal diagnosis of <b>Multiple Sclerosis</b> (e.g. magnetic resonance imaging, evoked potentials, cerebrospinal fluid analysis, etc.). Also, please <b>attach</b> a copy of all the relevant test reports.											
3) Name and address of the doctor who <b>First</b> diagnosed the patient with Multiple Sclerosis.											
4) Please describe in full details (with dates) the extent of neurological deficits.											
5) Based on your records, the multiple neurological deficits (described in Question 4) have occurred over a <b>continuous</b> period of at least _____ months. Please support with evidence.											
6) Is there a well-documented history of exacerbations and remissions of the said symptoms or neurological deficits? If "Yes", please elaborate with dates.											
<input type="checkbox"/> Yes <input type="checkbox"/> No											

7) Are the neurological deficits/damage due to:

(i) Systemic Lupus Erythematosus ("SLE")  Yes  No

(ii) Human Immunodeficiency Virus ("HIV")  Yes  No

(iii) Others (please specify):

8) Please provide details of current **treatment**, including name and dosage of medication, operation contemplated (if any).

10) Has the patient ever been hospitalised for Multiple Sclerosis or its related symptoms or complications?  Yes  No

If "Yes", please advise:

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

**D) Other Information**

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

2) Is there anything in the patient's **personal medical history** which would have increased the risk of Multiple Sclerosis? If "Yes", please give details:  Yes  No

<u>Exact diagnosis</u>	<u>Date of diagnosis</u>	<u>Name of doctor &amp; address of hospital/clinic</u>



8) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for **Multiple Sclerosis or any possible related illness**, especially any consultations concerning neurological symptoms or complaints, however minor in nature?  Yes  No  
 If "Yes", please give details:

<u>Name of doctor and Address of hospital/clinic</u>	<u>Date of first &amp; last consultation</u>	<u>Reasons for consultation</u>

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

10) Please enclose a copy of all reports including specialist or hospital reports, magnetic resonance imaging, evoked potentials result, cerebrospinal fluid analysis result, laboratory evidence, surgical report, 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 (ddmmyyy)	