* S U P D O C *

Singlife

Critical Illness Claim - Doctor's Statement
Progressive Scleroderma / Early Progressive Scleroderma / Systemic Sclerosis with CREST Syndrome

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 **Scleroderma**:

(i) Date the patient **First** consulted you for this 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)

(viii) Is the diagnosis of **Scleroderma** causing

(a) progressive diffuse fibrosis in the skin ❒ Yes ❒ No

(b) blood vessels ❒ Yes ❒ No

(c) visceral organs ❒ Yes ❒ No

(ix) Is the diagnosis of **Scleroderma** unequivocally supported by biopsy evidence? ❒ Yes ❒ No

If "Yes", please advise:

Date of biopsy test done (ddmmyyyy)	Detail of biopsy evidence to support the diagnosis

If "No", please state the clinical basis of the diagnosis of **Scleroderma.**

Please attach a copy of the biopsy reports.

(x) Is the diagnosis of **Scleroderma** unequivocally supported by serological evidence? ❒ Yes ❒ No

If "Yes", please advise:

Date of serological test done (ddmmyyyy)	Type(s)/Name(s) of serological test	Detail of serological evidence to support the diagnosis

If "No", please state the clinical basis of the diagnosis of **Scleroderma.**

Please attach a copy of the serological reports.

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

3) Please describe in detail the progression of the illness/condition since it was **First** diagnosed.

4) Please describe the extent of the illness/condition when the patient was **Last** seen at your hospital/clinic.

5) Is the heart involved in the diagnosis of **Scleroderma**? ❒ Yes ❒ No

If "Yes", please state the clinical basis of the heart involved in the diagnosis of **Scleroderma**.

6) Are the lungs involved in the diagnosis of **Scleroderma**? ❒ Yes ❒ No

If "Yes", please state clinical basis of the lungs involved in the diagnosis of **Scleroderma**.

7) Are the kidneys involved in the diagnosis of **Scleroderma**? ❒ Yes ❒ No

If "Yes", please state clinical basis of the kidneys involved in the diagnosis of **Scleroderma**.

8) Please state whether the patient is suffering from the following:

(i) Localised scleroderma (linear scleroderma or morphea) ❒ Yes ❒ No

(iii) Eosinophilic fascitis ❒ Yes ❒ No

If "Yes" to any of the above, please state date of **First** diagnosis (ddmmyyyy)

9) Please state whether the patient is suffering from CREST Syndrome? ❒ Yes ❒ No

If "Yes", please advise:

(i) Is there skin with deposits of calcium (calcinosis)? ❒ Yes ❒ No

(ii) Is there skin thickening of the fingers or toes (sclerodactyly)? ❒ Yes ❒ No

(iii) is there esophagus involved? ❒ Yes ❒ No

(iv) Is there telangiectasia (dilated capillaries)? ❒ Yes ❒ No

(v) Is there Raynaud's Phenomenon causing artery spasms in the extremities? ❒ Yes ❒ No

Please state date of **First** diagnosis (ddmmyyyy)

If "No" to i) to v), please state the clinical basis of the diagnosis with CREST Syndrome.

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10) 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.

11) Please provide details of **treatment** prescribed, with dates (e.g. immunosuppressive therapy, anti-fibrotic agents, etc.).

12) Is the patient's diagnosis directly or indirectly, wholly or partly caused by or arising from or contributed to by

(i) Human Immunodeficiency Virus (HIV)
or Acquired Immune Deficiency Syndrome (AIDS) infection? ❒ Yes ❒ No

If "Yes", please advise:

Date of Diagnosis of AIDS/HIV (dd/mm/yyyy) | | | | | | | | |

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 who **First** diagnosed the patient with HIV or AIDS, wilful misuse of alcohol, wilful misuse of drugs or congenital anomaly or defect.

Please provide copy of test result.

D) Other Information

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

2) Has the patient ever been hospitalised for Scleroderma 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

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3) Is there anything in the patient's **lifestyle** or **personal medical history** which would have increased the risk of Scleroderma? ❒ Yes ❒ No

If "Yes", please advise:

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

4) Has any of the patient's **family members** suffered from the condition? ❒ Yes ❒ No

If "Yes", please advise:

Relationship with patient	Nature of illness	Date of diagnosis	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.

7) Please describe the nature and severity of the patient's **physical** disability and limitation, if any.

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.

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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 **condition or any possible related illness**? ❒ 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) Biopsy reports
(ii) Blood test reports
(iii) Computerised tomography scan (CT scan)
(iv) Magnetic resonance imaging (MRI), other imaging studies
(v) Serological test reports
(vi) X-Ray
(vii) Operation reports, surgical reports
(viii) Referral letters (if any)
(ix) 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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