* S U P D O C *

Singlife

Critical Illness Claim - Doctor's Statement
Special Benefit - Dengue Haemorrhagic Fever

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?

(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 condition: (ddmmyyyy) | | | | | | | | |

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

3) Name and address of doctor that the patient is seeing for management of his/her medical condition.

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.

5) Is the diagnosis considered as

a) Dengue Haemorrhagic Fever Stage 3, based on the World Health Organisation? ❒ Yes ❒ No

b) Dengue Haemorrhagic Fever Stage 4, based on the World Health Organisation? ❒ Yes ❒ No

c) Other Stages of Dengue Haemorrhagic Fever, based on the World Health Organisation? ❒ Yes ❒ No

Please provide the Stage: _____

If "Yes" to any of above, please provide the following (i) to (vii).

(i) Is the dengue infection confirmed by a serological testing? ❒ Yes ❒ No

If "Yes", please provide the result(s) of the serological test(s) which confirmed the diagnosis:

Type of test/assessment	Date of test/assessment	Results of test/assessment

(ii) Is there history of continuous high fever for two (2) or more days? ❒Yes ❒ No

If "Yes", please provide the following dates (dd/mm/yyyy):

From

To

(iii) Are there minor or major haemorrhagic manifestations? ❒Yes ❒ No

If "Yes", please provide the result(s).

(iv) Is there thrombocytopenia (less than or equal to 100000 per mm^3)? ❒ Yes ❒ No
If "Yes", please provide the result(s).

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(v) Is there haemoconcentration (haematocrit increased by 20% or more)? ❒ Yes ❒ No

If "Yes", please provide the result(s).

(vi) Is there evidence of evidence of plasma leakage (i.e. pleural effusion, ascites or hypoproteinaemia, etc.)? ❒ Yes ❒ No

If "Yes", please provide details of the plasma leakage:

Type of test/assessment	Date of test/assessment	Results of test/assessment

(vii) Is there evidence of Dengue Shock Syndrome (DSS)? ❒ Yes ❒ No

a) Is there evidence of hypotension (less than 80 mm Hg) or narrow pulse pressure (20 mm Hg or less)? ❒ Yes ❒ No

b) Is there evidence of tissue hypoperfusion such as cold, clammy skin, oliguria, or metabolic acidosis? ❒Yes ❒ No

If "Yes", please provide details of the Dengue Shock Syndrome (DSS):

Type of test/assessment	Date of test/assessment	Results of test/assessment

Please provide the results of investigations done and attach copies of reports.

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6) 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 the medical 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

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3) 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.

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

5) 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.

6) a) Is the patient mentally incapacitated? ❒ Yes ❒ No

b) If the patient is mentally incapacitated, is he/she mentally capable of receiving or handling money? ❒ Yes ❒ No

7) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for the **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

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

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

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