



**Living Benefit Claim - Doctor's Statement
Pregnancy Complications Benefit – Abruptio Placentae**

SECTION 2 – 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) <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) 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):	<table border="1" style="width:100%; height: 40px; 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>								

2) Are you the patient's usual medical doctor? If "Yes", since when? (ddmmyyyy) If "No", please provide name and address of the patient's regular doctor.	<input type="checkbox"/> Yes <input type="checkbox"/> No <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>								

3) Was the patient referred to you? If "Yes", please provide: (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.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <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>								

4) Have you referred the patient to any other doctor? (i) Date referred (ddmmyyyy) (ii) Reason for referral: (iii) Name and address of doctor referred to:	<input type="checkbox"/> Yes <input type="checkbox"/> No <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>								

5) Does the patient have or ever have had any significant health conditions, medical history or any illness (e.g. tumour, diabetes, hypertension, hyperlipidaemia, anaemia 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 smoking , 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 alcohol consumption , 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 Abruptio Placentae condition.											
(i) Date the patient First consulted you 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, and date these symptoms first started.											
(iii) Exact Diagnosis of the condition: ICD-10 Code (if applicable):											
(iv) 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>										
(v) Date the patient First became aware of 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>										
2) Did abruptio placentae occur after the 20 th week of gestation and prior to the birth of the foetus?	<input type="checkbox"/> Yes <input type="checkbox"/> No										
3) Were there foetal distress or maternal shock?	<input type="checkbox"/> Yes <input type="checkbox"/> No										

4) Were there class 2 or class 3 abruption?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
5) Was an emergency caesarean section performed for the condition? If "Yes", please state date of surgery (ddmmyyyy) and provide a copy of the operation report.	<input type="checkbox"/> Yes <input type="checkbox"/> No								
<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>									
6) What is the underlying cause(s) of the abruptio placentae?									
7) Was this pregnancy conceived through any of the following fertility treatments:									
(a) Vitro Fertilization (IVF)	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(b) Intra-Cytoplasmic Sperm (ICSI)	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(c) Intrauterine Insemination (IUI)	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(d) Intracervical Insemination (ICI)	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(e) If none of the above, please specify the fertility treatment that the patient has received:									
8) Was the patient carrying 5 or more babies in this pregnancy? If "No", please state the number of babies that the patient has carried in this single pregnancy.	<input type="checkbox"/> Yes <input type="checkbox"/> No								
9) Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? If "Yes", please provide the date of HIV/AIDS diagnosis (ddmmyyyy).	<input type="checkbox"/> Yes <input type="checkbox"/> No								
<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>									
10) Is the diagnosis related to self-inflicted injury, suicide or attempted suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
11) Is the diagnosis related to any deliberate misuse of any drugs or alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
12) Is the diagnosis related to the use of unprescribed drugs where such drugs are required by the law to be prescribed by a registered medical doctor?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
13) Please enclose a copy of all reports including specialist or hospital reports, laboratory evidence, surgical report, etc.									
D) 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 (dd/mm/yyyy)									