



Living Benefit Claim - Doctor's Statement
Pregnancy Complications Benefit – Still Birth

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)

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?
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?
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.)

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:

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 Still Birth condition.											
(i) Date the patient First consulted you for this condition (ddmmyyyy)	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <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 (ddmmyyyy)	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> </tr> </table>										
(v) Date the patient First became aware of this condition (ddmmyyyy)	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> </tr> </table>										
2) Date of termination of pregnancy (ddmmyyyy)	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> </tr> </table>										
3) Please state the number of gestational weeks on the day of termination of pregnancy.											

