



**Living Benefit Claim - Doctor's Statement
 Pregnancy Complications Benefit
 Uterine Infection or Transfusion Due to Retained Placenta Following Childbirth**

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)	<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?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(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. tumour, diabetes, hypertension, hyperlipidaemia, anaemia etc.)? Yes No
 If "Yes", please provide:
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 **Uterine Infection or Transfusion Due to Retained Placenta Following Childbirth** condition

(i) Date the patient First consulted you for this condition (ddmmyyy)

--	--	--	--	--	--	--	--	--	--

(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)

--	--	--	--	--	--	--	--	--	--

(v) Date the patient **First** became aware of this condition (ddmmyyy)

--	--	--	--	--	--	--	--	--	--

2) Did the patient underwent surgical removal for a retained placenta after a term vaginal delivery? If "Yes", please provide copy of operation report.	<input type="checkbox"/> Yes <input type="checkbox"/> No								
3) Did the patient underwent surgery with intravenous antibiotics?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
4) Did the patient underwent surgery with a transfusion for excessive blood loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
5) Did the patient underwent surgery or other treatment for incomplete uterine evacuation following miscarriage or termination of pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
6) 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:									
7) 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									
8) 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 (dd/mm/yyyy)	<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>								
9) Is the diagnosis related to self-inflicted injury, suicide or attempted suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
10) Is the diagnosis related to any deliberate misuse of any drugs or alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
11) 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								
12) 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 (ddmmyyyy)									