



**Critical Illness Claim – Doctor’s Statement
Alzheimer’s Disease / Severe Dementia / Early Dementia /
Moderately Severe Dementia including Alzheimer’s Disease**

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)								
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B) Patient’s Medical Records									
1) Please indicate the period that is documented in the hospital/clinic’s record:									
(i) Date of First Consultation (ddmmyyyy)	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>								
(ii) Date of Last Consultation (ddmmyyyy)	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>								
(iii) Number of consultations during the above period:									
(iv) Name of hospital/clinic and reason(s) 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"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></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"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>								
(ii) Reason for referral:									
(iii) Name and address of referring doctor:									
If “No”, please indicate how the patient came 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"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></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, stroke, diabetes, hypertension, hyperlipidaemia, hepatitis, etc.)? Yes No
 If "Yes", please advise:

<u>Details of symptoms</u>	<u>Exact diagnosis</u>	<u>Date diagnosed</u>	<u>Treatment</u>

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 past and present **smoking** habits, 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 **alcohol consumption** habits, 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 the condition:

(i) Date the patient **First** consulted you for the condition (ddmmyyyy)

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(ii) Details of symptom(s) presented during the **First** consultation.

(iii) Date of onset of these symptoms (ddmmyyyy)

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(iv) What is/are the underlying cause(s) of the symptoms?

(v) **Final** Diagnosis of the condition:

(vi) ICD-10 Code:

(vii) Date of First Diagnosis (ddmmyyyy)

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(viii) Date the patient **First** became aware of the illness/condition
(ddmmyyyy)

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

3) Please provide full details and results of all **investigation** (with dates) performed for the diagnosis.
Also, please **attach** a copy of all relevant test reports including brain scans, Mini-mental State Examination (MMSE),
Alzheimer's Disease Assessment Scale-Cognitive etc.

Please advise:

Type of Test/Assessment	Date of Test/Assessment (ddmmyyyy)	Results of Test/Assessment

4) Did the patient undergo Mini-Mental State Examination (MMSE)?
If "Yes", please advise:

Yes No

a)

Date of MMSE (ddmmyyyy)	Results of MMSE

b) Result of MMSE based on current severity of patient's diagnosis:

5) Did the patient undergo disease modifying treatment prescribed by a Neurologist? Yes No
 If "Yes", please advise:

a)

Date of disease modifying treatment started (ddmmyyyy)	Date of disease modifying treatment completed (ddmmyyyy)

b) Did the patient undergone neuropsychometric tests performed 6 months apart? Yes No
 If "Yes", please provide details.

6) Is there evidence of deterioration or loss of intellectual capacity or abnormal behaviour resulting in significant reduction in mental and social functioning? Yes No
 If "Yes", please describe the findings.

7) Does the patient require **continuous** supervision because of the significant reduction in mental and social functioning mentioned in Question 6? Yes No
 If "Yes", please provide the basis of your evaluation and state the date on which such continuous supervision was first required.

8) Was there irreversible deterioration or loss of cognitive function that has persisted for at least 6 months? Yes No

If "Yes", please advise:

Date of initial commencement (ddmmyyyy)

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9) Did the patient undergo psychometric assessment instructed by a Geriatrician, Psychiatrist (including Geriatric Psychiatrist) or Neurologist? Yes No

If "Yes", please advise:

a)

Date of Psychometric Assessment (ddmmyyyy)	Psychometric Assessment i.e. Clinical Dementia Rating (CDR), Global Deterioration Scale (GDS) or Functional Assessment Staging Tool (FAST)	Result of Psychometric Assessment

10) Please describe the progression of the patient's Alzheimer's disease/dementia condition since the time he/she was **First** and **last seen** at your hospital/clinic (e.g. memory and thinking changes, etc.)

11) How has the patient been coping with the condition during this period?

12) Is diagnosis directly or indirectly, wholly or partly caused by, arising from, or contributed to by any of the following?

(i) Non-organic diseases such as neurosis, pseudodementia or psychiatric illness/disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(ii) Head injury related brain damage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(iii) Alcohol related brain damage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(iv) Drug related brain damage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(v) Wilful misuse of drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(vi) Any other disease/infections (e.g. HIV-related infections, encephalitis, hypothyroidism, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(vii) Congenital anomaly or defect?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 non-organic diseases, head injury, alcohol related, drug related, wilful misuse of drugs, any other disease/infection or congenital anomaly or defect.

Please provide copy of test result.

13) Is there permanent clinical loss of the ability to do any of the following

(i) Remember?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(ii) Reason?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(iii) Perceive, understand, express, and give effect to ideas?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

14) Has the patient previously ever suffered from any neurosis or any other psychiatric disorder? Yes No

If "Yes", please provide:

<u>Resulting diagnosis</u>	<u>Date of diagnosis</u>	<u>Date of First & Last consultation</u>	<u>Name of doctor & Address of hospital/clinic</u>
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15) Has the patient ever been hospitalised or institutionalised because of any neurosis or psychiatric disorder? Yes No

If "Yes", please provide details of the stay:

<u>Period of Stay</u>	<u>Reasons for Stay</u>	<u>Treatment received (including operation, if any)</u>	<u>Name of doctor/surgeon & Address of hospital /clinic</u>
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16) Please provide details of current **treatment** received for Alzheimer's Disease/Severe Dementia, including the name and dosage of medication, operation contemplated (if any)?

17) Can the condition be controlled with medication? Yes No
 If "Yes", please state date the medical treatment **First** started (ddmmyyyy)

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18) Are there signs of progressive impairment? Yes No
 If "Yes", please elaborate (with dates) on how the condition has deteriorated over time.

19) Has the patient previously suffered from the condition(s) specified above or any possible related illnesses or conditions, however minor in nature, which caused the deterioration or loss of intellectual capacity? Yes No
 If "Yes", please advise:
Exact diagnosis Date of diagnosis Name of doctor & Address of hospital/clinic

D) Other Information

1) Was the patient admitted to a hospital for treatment of the diagnosis? Yes No
 If "Yes", please advise:

Name of the hospital		
Admission Date and Time (ddmmyyyy; hh:mm)		
Discharge Date and Time (ddmmyyyy; hh:mm)		
Name of the hospital		
Admission Date and Time (ddmmyyyy; hh:mm)		
Discharge Date and Time (ddmmyyyy; hh:mm)		

2) Was the patient admitted to Intensive Care Unit (ICU) for treatment of the diagnosis?

Yes No

If "Yes", please advise:

Name of the hospital		
Admission Date and Time (ddmmyyyy; hh:mm)		
Discharge Date and Time (ddmmyyyy; hh:mm)		
Name of the hospital		
Admission Date and Time (ddmmyyyy; hh:mm)		
Discharge Date and Time (ddmmyyyy; hh:mm)		

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

4) Is there anything in the patient's **lifestyle** or **personal medical history** that may have increased the patient's risk of suffering from the condition?

Yes No

If "Yes", please advise:

Type of Lifestyle / Exact diagnosis

Date of diagnosis

Name of doctor & Address of hospital/clinic

5) Is there anything in the patient's **family history** that may have increased the patient's risk of suffering from the condition?

Yes No

If "Yes", please advise:

Relationship with patient

Nature of condition

Age of onset

Source of information

<p>6) Have active treatment and therapy now been rejected in favour of relief of symptoms? If "Yes", please provide full details and explain the reason for this course of action.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>7) Based on the Last consultation and despite all reasonable medical treatment, is the condition highly likely to lead to death within the next:</p>	
<p>(i) Six (6) months?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>(ii) Twelve (12) months?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>If "Yes" to (i) and/or (ii), please advise:</p>	
<p>a) Medical treatment(s) that had been provided to the patient</p>	
<p>b) Prognosis after undergoing the mentioned medical treatment(s)</p>	
<p>c) Any other details on the basis of your evaluation.</p>	
<p>8) Please describe and elaborate on the nature and severity of the patient's physical disability and limitation(s).</p>	
<p>9) Please describe and elaborate on the nature and severity of the patient's mental disability and limitation(s), including the degree of intellectual impairment.</p>	
<p>10) Was there any memory impairment in the following cognitive areas?</p>	
<p>(i) Aphasia (language)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>(ii) Apraxia (motor)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>(iii) Agnosia (sensory)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>(iv) Disturbance in executive functioning (e.g. planning, focus attention, organising, completing tasks)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>If "Yes" to any of the above, please elaborate including <u>date of diagnosis</u>, <u>name and address of the Neurologist</u> who made the diagnosis and <u>source of information</u>.</p>	

11) (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

12) Are you aware of any other doctor(s), in Singapore or overseas, whom the patient consulted for the **condition or any other related diseases**? Yes No

If "Yes", please advise:

<u>Name of doctor and Address of hospital/clinic</u>	<u>Date of First & Last consultation</u>	<u>Reasons for consultation</u>

13) Is the patient still on follow-up at your hospital/clinic? Yes No

If "Yes", please state date of next appointment (ddmmyyyy)

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If "No", please state date of discharge (ddmmyyyy), if any.

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14) Please provide us with any other additional information that may assist the Company in assessing this claim.

Please enclose copies of all investigation reports including specialist, hospital and laboratory reports. Where applicable, please provide the following:

- (i) Alzheimer's Disease Assessment Scale-Cognitive reports
- (ii) Computerised tomography scan (CT scan)
- (iii) Magnetic resonance imaging (MRI), other imaging studies
- (iv) Mini-Mental State Examination (MMSE)
- (v) Positron emission tomography scan (PET scan)
- (vi) Psychometric assessments such as Clinical Dementia Rating (CDR), Functional Assessment Staging Tool (FAST) and Global Deterioration Scale (GDS) reports
- (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 & Official Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	