Living Benefit Claim - Doctor's Statement
Hospital Care / Stem Cell Treatment / Developmental Delay Benefit for Child

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 / Passport / Birth Certificate No.	Date of Birth (ddmmyyyy)

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):
   - (ii) Date of **Last** consultation (ddmmyyyy):
   - (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? ❒ 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 provide:
   - (i) Date referred (ddmmyyyy):
   - (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? ❒ 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, any illness or any congenital condition? ❐ 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?

C) Details of Illness

1) Please **tick (√) the relevant box(es) to indicate the condition(s) related to this doctor's report**:

- ❐ Admission into Neonatal Intensive Care Unit (NICU) or High Dependency Unit (HDU)
- ❐ Premature birth requiring neo-natal ICU/HDU
- ❐ Incubation of the newborn child for more than 3 consecutive days immediately following birth
- ❐ Phototherapy or Blood Transfusion for severe neonatal jaundice
- ❐ Hospitalisation due to Hand, Foot and Mouth Disease
- ❐ Stem cell treatment
- ❐ Developmental delay

2) Please provide details of the condition.

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

(ii) Details of symptom(s) presented at **First** consultation:

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

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

(v) ICD-10 Code:

(vi) Date of **First** diagnosis (ddmmyyyy) | | | | | | | | |

(vii) Date the patient **First** became aware of the illness/ condition (ddmmyyyy): | | | | | | | | |

3) Was the patient born prematurely? If "Yes", please provide the details. ❐ Yes ❐ No

(i) Gestation period ______ weeks (ii) Birth weight ______ grams

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4) Was the patient incubated for more than 3 consecutive days immediately following birth? ❐ Yes ❐ No

If "Yes", please advise the period of incubation (ddmmyyyy):

From: | | | | | | | | | a.m. / p.m.

To: | | | | | | | | | a.m. / p.m.

5) Was the patient admitted to a Neonatal Intensive Care Unit (NICU)? ❐ Yes ❐ No

If "Yes", please advise the period of confinement (ddmmyyyy):

From: | | | | | | | | | a.m. / p.m.

To: | | | | | | | | | a.m. / p.m.

6) Was the patient admitted to a High Dependency Unit (HDU)? ❐ Yes ❐ No

If "Yes", please advise the period of confinement (ddmmyyyy):

From: | | | | | | | | | a.m. / p.m.

To: | | | | | | | | | a.m. / p.m.

7) Was the patient admitted to a Special Care Nursery (SCN)? ❐ Yes ❐ No

If "Yes", please state the period of confinement (ddmmyyyy):

From: | | | | | | | | | a.m. / p.m.

To: | | | | | | | | | a.m. / p.m.

Was the Special Care Nursery (SCN) classified as:

(i) Neonatal Intensive Care Unit (NICU) in your hospital? ❐ Yes ❐ No

(ii) High Dependency Unit (HDU) in your hospital? ❐ Yes ❐ No

If "Yes", please provide the reason of admitting the patient to the SCN, instead of NICU or HDU.

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8) Did the patient require:

(i) Outpatient treatment for at least 3 consecutive days for treatment? ❒ Yes ❒ No

(ii) Hospitalisation for at least 3 consecutive days for treatment? ❒ Yes ❒ No

If "Yes", please advise:

a) Period of confinement (ddmmyyyy):

From: | | | | | | | | | | a.m. / p.m.

To: | | | | | | | | | | a.m. / p.m.

b) Was the hospitalisation for at least 3 consecutive days for treatment with:

i. Phototherapy within 30 days after birth? ❒ Yes ❒ No

ii. Blood transfusion within 30 days after birth? ❒ Yes ❒ No

(iii) Please confirm the following:

a) Was there presence of neonatal jaundice? ❒ Yes ❒ No

If "Yes", please advise the **total serum bilirubin level below:**

i. For **term infant, at or greater than 37 weeks gestational age**:

a) 25 to 72 hours after birth: ______ μ mol/L (micromol/litre)

b) More than 72 hours after birth: ______ μ mol/L (micromol/litre)

c) Please provide copy of diagnostic and blood test results.

ii. For **pre-matured infants, at less than 37 weeks gestational age**:

a) 25 to 72 hours after birth: ______ μ mol/L (micromol/litre)

b) More than 72 hours after birth: ______ μ mol/L (micromol/litre)

c) Please provide copy of diagnostic and blood test results.

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9) Was the patient hospitalised for **Hand, Foot and Mouth (HFM) disease**? ❒ Yes ❒ No

If "No", please proceed to **question 10**.

If "Yes", please advise:

(i) Date of admission (ddmmyyyy): | | | | | | | | |

(ii) **Provisional diagnosis** on admission:

(iii) Were there any viral study done to confirm the diagnosis of HFM Disease? ❒ Yes ❒ No
If "Yes", please indicate the investigations carried out and their results.

(iv) Did the patient suffer from:

(a) Encephalitis during this admission? ❒ Yes ❒ No

(b) Myocarditis during this admission? ❒ Yes ❒ No

If "Yes", please provide documented evidence of the presence of the encephalitis or myocarditis.

(v) Was positive isolation of the causative virus carried out during this admission? ❒ Yes ❒ No

(vi) Was the following diagnosed during the admission?

(a) Coxsackie A17 ❒ Yes ❒ No

(b) Enterovirus 71 ❒ Yes ❒ No

(vii) Did the patient suffer any neurological deficit after the date of diagnosis of the HFM Disease? ❒ Yes ❒ No

If "Yes", please advise:

(a) Neurological deficits suffered:

(b) Was there evidence of neurological deficit that lasted at least 30 days after the date of diagnosis of the HFM Disease was established? ❒ Yes ❒ No

If "Yes", please provide full details:

10) (i) Was the patient's actual age 28 months from the date of birth? ❒ Yes ❒ No

If "No", please advise the actual age of the patient:

(i) Was the patient able to perform the activities below:

(a) Walk without aid over a distance of 2 meters ❒ Yes ❒ No

(b) Speak and say simple words such as "papa", "mama" and etc ❒ Yes ❒ No

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11) Was the patient hospitalised for **stem cell transplant surgery**? ❒ Yes ❒ No

If "No", please proceed to **question 12**.

If "Yes", pleaseadvise:

(i) Date of surgery (ddmmyyyy):

(ii) Date started the process of injection or extraction of stem cells (ddmmyyyy):

(iii) Prognosis of the stem cell transplant:

12) What is/are the underlying cause(s) of the condition?

13) Was this pregnancy conceived through any of the following fertility treatments:

(i) Vitro Fertilization (**IVF**) ❒ Yes ❒ No

(ii) Intra-Cytoplasmic Sperm (**ICSI**) ❒ Yes ❒ No

(iii) Intrauterine Insemination (**IUI**) ❒ Yes ❒ No

(iv) Intracervical Insemination (**ICI**) ❒ Yes ❒ No

Please specify the fertility treatment that the patient has received if none of the above applies:

14) Was the patient's mother carrying 5 or more babies in this pregnancy? ❒ Yes ❒ No

If "No", please indicate the **number** of babies that the patient has carried in this pregnancy.

15) Is the diagnosis directly or indirectly, wholly or partly caused by, arising from, or contributed to by any complication resulting from fertility treatment(s)? ❒ Yes ❒ No

16) Is the diagnosis directly or indirectly, wholly or partly caused by, arising from, or contributed to by Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) infection? ❒ Yes ❒ No

If "Yes", please advise:

Date of Diagnosis of AIDS/HIV (ddmmyyyy):								
Date the patient **First** became aware of the condition (ddmmyyyy):								

If "Yes", please provide the details including name of doctor / clinic where the patient was **First** diagnosed with HIV or AIDS.

Please provide a copy of the relevant test result(s).

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

(i) Self-inflicted illness, injury, suicide or attempted suicide? ❒ Yes ❒ No

(ii) Deliberate misuse of alcohol? ❒ Yes ❒ No

(iii) Deliberate misuse of drugs? ❒ Yes ❒ No

(iv) Use of unprescribed drugs where such drugs are required by law to be prescribed by a registered medical practitioner? ❒ Yes ❒ No

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

If “Yes”, please state date of next appointment (ddmmyyyy):

If “No”, please state date of discharge (ddmmyyyy), if any:

19) 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.

D) 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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