



Living Benefit Claim - Doctor's Statement Disseminated Intravascular Coagulation

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: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td> </tr> </table>								
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" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td> </tr> </table>								
(ii) Date of Last consultation (ddmmyyyy):	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </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: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </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 advise:									
(i) Date referred (ddmmyyyy):	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </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" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </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 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?

8) Please give details of the patient's past and present **smoking** habit(s), 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 **alcohol consumption** habit(s), 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 the condition:

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

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

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

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

(v) ICD-10 Code:

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

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

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<p>2) Please provide full details and results of all investigation(s) (with dates) performed for the diagnosis. Also, please attach a copy of all relevant test reports.</p>										
<p>3) Name and address of the doctor who First diagnosed the patient with the condition:</p>										
<p>4) Was there presence of:</p> <table style="width: 100%; border: none;"> <tr> <td style="padding-left: 20px;">(i) Over activation of the coagulation and fibrinolytic system:</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td style="padding-left: 20px;">(ii) Microvascular thrombosis:</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td style="padding-left: 20px;">(iii) Consumption of platelets and coagulation factors:</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td style="padding-left: 20px;">(iv) Major haemorrhage:</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td style="padding-left: 20px;">(v) Treatment with frozen plasma and platelet concentrates:</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table> <p>If "Yes", please provide copy of the investigation results to support:</p>	(i) Over activation of the coagulation and fibrinolytic system:	<input type="checkbox"/> Yes <input type="checkbox"/> No	(ii) Microvascular thrombosis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	(iii) Consumption of platelets and coagulation factors:	<input type="checkbox"/> Yes <input type="checkbox"/> No	(iv) Major haemorrhage:	<input type="checkbox"/> Yes <input type="checkbox"/> No	(v) Treatment with frozen plasma and platelet concentrates:	<input type="checkbox"/> Yes <input type="checkbox"/> No
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(v) Treatment with frozen plasma and platelet concentrates:	<input type="checkbox"/> Yes <input type="checkbox"/> No									
<p>5) What was the underlying cause of disseminated intravascular coagulation?</p>										
<p>6) Did the disseminated intravascular coagulation occur because of pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please provide details:</p>										
<p>7) Did the disseminated intravascular coagulation occur within First seven months of pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>										
<p>8) Was this pregnancy conceived through any of the following fertility treatments:</p> <table style="width: 100%; border: none;"> <tr> <td style="padding-left: 20px;">(i) Vitro Fertilization (IVF):</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td style="padding-left: 20px;">(ii) Intra-Cytoplasmic Sperm (ICSI):</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td style="padding-left: 20px;">(iii) Intrauterine Insemination (IUI):</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td style="padding-left: 20px;">(iv) Intracervical Insemination (ICI):</td> <td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table> <p>If none of the above, please specify the fertility treatment that the patient has received:</p>	(i) Vitro Fertilization (IVF):	<input type="checkbox"/> Yes <input type="checkbox"/> No	(ii) Intra-Cytoplasmic Sperm (ICSI):	<input type="checkbox"/> Yes <input type="checkbox"/> No	(iii) Intrauterine Insemination (IUI):	<input type="checkbox"/> Yes <input type="checkbox"/> No	(iv) Intracervical Insemination (ICI):	<input type="checkbox"/> Yes <input type="checkbox"/> No		
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(iii) Intrauterine Insemination (IUI):	<input type="checkbox"/> Yes <input type="checkbox"/> No									
(iv) Intracervical Insemination (ICI):	<input type="checkbox"/> Yes <input type="checkbox"/> No									
<p>9) Was the patient carrying 5 or more babies during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please indicate the number of babies that the patient carried during the pregnancy.</p>										

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

(i) Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) infection? Yes No

If "Yes", please provide details:

Date of Diagnosis of AIDS/HIV (ddmmyyy):

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

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- (ii) Deliberate misuse of alcohol? Yes No
- (iii) Deliberate misuse of drugs? Yes No
- (iv) Self-inflicted illness, injury, suicide or attempted suicide? Yes No
- (v) Use of unprescribed drugs where such drugs are required by law to be prescribed by a registered medical practitioner? Yes No
- (vi) Pregnancy complications from fertility treatments? Yes No
- (vii) Elective abortions? Yes No
- (viii) Complications arising from child delivery in overseas hospitals and hospitalisation occurring overseas? Yes 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 where the patient was **First** diagnosed with HIV or AIDS, deliberate misuse of alcohol, deliberate misuse of drugs, use of unprescribed drugs where such drugs are required by law to be prescribed by a registered medical practitioner, pregnancy complications from fertility treatments, elective abortions or complications arising from child delivery in overseas hospitals and hospitalisation occurring overseas.

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

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

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

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If "No", please state date of discharge (ddmmyyy), if any:

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12) 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) Blood test reports
- (ii) Computerised tomography scan (CT scan)
- (iii) Magnetic resonance imaging (MRI), other imaging studies
- (iv) Ultrasound reports
- (v) X-Ray
- (vi) Operation reports, surgical reports
- (vii) Referral letters (if any)
- (viii) Any other investigation reports

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 (ddmmyyy)	