Critical Illness Claim - Doctor's Statement
Severe Bacterial Meningitis / Bacterial Meningitis

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 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 reasons 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, or any illness (e.g. brain herniation, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, 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 provide 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 provide 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): | | | | | | | | |

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

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

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

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

(vi) ICD-10 Code:

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

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

2) Is there any severe inflammation of the membranes of the brain or spinal cord? ❒ Yes ❒ No

If "Yes", were appropriate investigations (including Lumbar puncture test) performed to prove the severe inflammation of the membranes of the brain or spinal cord? ❒ Yes ❒ No

Please describe in full details (with dates) of the investigations performed.

Date of investigations (ddmmyyyy)	Types of investigations performed	Details of investigations

Please **attach** a copy of relevant test reports.

3) Please describe in full details (with dates) the extent of neurological deficits.

Date of initial episode (ddmmyyyy)	Types of neurological deficits experienced	Duration of symptoms

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4) Was there any neurological deficit (described in Question 3) lasting for a **continuous** period of at least six (6) weeks? ❒ Yes ❒ No

If "Yes", please provide details on the permanent neurological deficit with persisting clinical symptoms which indicate symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the lifetime of the patient:

Please tick	Neurological deficit	Date of last review confirming the neurological deficit (ddmmyyyy)	Please specify the exact body part(s) affected	Is the neurological deficit permanent and expected to last throughout the lifetime?	Please elaborate with supporting evidence
	Numbness			Yes / No	
	Paralysis			Yes / No	
	Localised weakness			Yes / No	
	Dysarthria (difficulty with speech)			Yes / No	
	Aphasia (inability to speak)			Yes / No	
	Dysphagia (difficulty swallowing)			Yes / No	
	Visual Impairment			Yes / No	
	Difficulty in walking			Yes / No	
	Lack of coordination			Yes / No	
	Tremor			Yes / No	
	Seizures			Yes / No	
	Dementia			Yes / No	
	Delirium			Yes / No	
	Coma			Yes / No	
	Others, please specify:			Yes / No	

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5) Are the neurological deficits irreversible? ❒ Yes ❒ No

(i) If "Yes", please elaborate with supporting evidence:

(ii) If "No", please state date of recovery *or* date for which the patient is likely to recover from these neurological deficits (ddmmyyyy):

6) Please provide full details and results of **investigation(s)** performed (with dates) performed for the diagnosis.

Also, please **attach** a copy of all relevant test reports for affected areas including **the cerebrospinal fluid and blood culture, stating the types of organism(s) found for each area etc.**

7) What was the cerebrospinal fluid collection method?

8) Was lumbar puncture performed for the collection of cerebrospinal fluid? ❒ Yes ❒ No

9) Was there any presence of bacterial infection in cerebrospinal fluid by lumbar puncture? ❒ Yes ❒ No

If "Yes", were there appropriate investigation(s) (including Lumbar puncture test) performed to prove the bacterial infection? ❒ Yes ❒ No

Please describe in full details (with dates) of the investigations performed.

Date of investigations (ddmmyyyy)	Types of investigations performed	Details of investigations

Please **attach** a copy of all relevant test reports.

10) Name and address of the **neurologist** who **First** diagnosed the patient with the condition:

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11) Please provide details of ongoing **treatment**, including name and dosage of medication, operation contemplated (if any).

12) Was the patient admitted at the 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)		

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

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14) Is the patient's diagnosis or surgery 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 advise:

Date of Diagnosis of AIDS/HIV (ddmmyyyy): | | | | | | | | |

Date the patient First became aware of the condition (ddmmyyyy): | | | | | | | | |

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

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

(iv) Congenital anomaly or defect? ❒ 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** with HIV or AIDS, wilful misuse of alcohol, wilful misuse of drugs or congenital anomaly or defect.

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

D) Other Information

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

2) Is there anything in the patient's **lifestyle** or **personal medical history** that may have increased the risk of the condition? ❒ Yes ❒ No

If "Yes", please advise:

Type of Lifestyle / Exact diagnosis | Date of diagnosis | Name of doctor & address of hospital/clinic

3) Is there anything in the patient's **family history** that may have increased the risk of the condition? ❒ Yes ❒ No

If "Yes", please advise:

Relationship with patient | Nature of condition | Age of onset | Source of information

4) Have active treatment and therapy now been rejected in favour of relief of symptoms? ❒ Yes ❒ No

If "Yes", please provide full details and explain the reason for this course of action.

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5) Based on the **Last** consultation and despite all reasonable medical treatment, is the condition highly likely to lead to death within the next:

(i) Six (6) months? ❒ Yes ❒ No

(ii) Twelve (12) months? ❒ Yes ❒ No

If "Yes" to (i) and/or (ii), please advise:

a) Medical treatment(s) that had been provided to the patient

b) Prognosis after undergoing the mentioned medical treatment(s)

c) Any other details on the basis of your evaluation.

6) Please describe and elaborate on the nature and severity of the patient's **physical** disability and limitation(s).

7) Please describe and elaborate on the nature and severity of the patient's **mental** disability and limitation(s), including the degree of cognitive and/or intellectual impairment.

8) (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

9) 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:

Name of doctor and Address of hospital/clinic	Date of **First** & **Last** consultation	Reasons for consultation

10) 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. | | | | | | | | |

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11) 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) Cerebrospinal fluid analysis result reports
(iii) Computerised tomography scan (CT scan)
(iv) Magnetic resonance imaging (MRI), other imaging studies
(v) X-Ray
(vi) Operation reports, surgical reports
(vii) Referral letters (if any)
(viii) 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 & Offical Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	

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