* S U P D O C *

Critical Illness Claim - Doctor's Statement
Blindness (Irreversible Loss of Sight) / Irreversible Loss of sight in one eye or Optic Nerve Atrophy with low vision

DOCTOR'S STATEMENT (to be completed by the attending doctor at claimant's expense)

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 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 advise:

(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. glaucoma, tumour, hepatitis, 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 provide 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.

No. of years of smoking	No. of sticks per day	Source of information

9) Please provide 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 the condition:

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

(ii) Details of symptom(s) presented during the **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) Please provide full details and results of all **investigations** (with dates) performed for the condition.
Also, please **attach** a copy of all the relevant test reports**.**

3) Name and address of the ophthalmologist who **First** diagnosed the patient with the diagnosis.

4) What is the current **visual acuity** of both eyes using Snellen eye chart?

Left Eye:

Date of Assessment (Left Eye) (ddmmyyyy):

Right Eye:

Date of Assessment (Right Eye) (ddmmyyyy):

5) What is the current **visual field** in both eyes?

Left Eye:

Date of Assessment (Left Eye) (ddmmyyyy):

Right Eye:

Date of Assessment (Right Eye) (ddmmyyyy):

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6) Is the visual loss permanent and irreversible in

(i) Left eye? ❒ Yes ❒ No

(ii) Right eye? ❒ Yes ❒ No

If "Yes", please elaborate:

7) Is there any surgical procedure(s), implant(s) or any other means of surgery available that could reinstate vision in either or both eyes? ❒ Yes ❒ No

If "Yes", please advise:

(i) Nature of surgery:

(ii) What is the best possible corrected visual acuity of both eyes:

Left Eye: Right Eye:

(iii) Has such surgery been recommended to the patient? ❒ Yes ❒ No

If "No", why not?

(iv) Tentative Date of Surgery (ddmmyyyy): | | | | | | | | |

8) Has the patient sufferred from **Optic Nerve Atrophy with low vision**? ❒ Yes ❒ No

If "No", please proceed to **Question 9**.

If "Yes", please advise:

(i) How was the diagnosis of optic nerve atrophy established?

(ii) Are both eyes affected as a result of optic nerve atrophy? ❒ Yes ❒ No

If 'Yes", please provide details.

(iii) What is the best corrected **visual acuity** of both eyes using the Snellen eye chart?

Left Eye: Right Eye:

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9) 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)		

10) 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)		

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9) 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 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** diagnosed with HIV or AIDS, wilful misuse of alcohol, wilful misuse of drugs or congenital anomaly or defect.

Please provide a 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 **Blindness**? ❒ Yes ❒ No

If "Yes", please advise:

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

3) Has any of the patient's **family members** suffered from eye disease including blindness, cataract, or retinitis pigmentosa and etc? ❒ Yes ❒ No

If "Yes", please advise:

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

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4) Have active treatment and therapy been rejected in favour of the relief of symptoms? ❒ Yes ❒ No
If "Yes", please provide full details and explain the reason for this course of action.

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 **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

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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: | | | | | | | | |

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 include the following:

(i) Computerised tomography scan (CT scan)
(ii) Magnetic resonance imaging (MRI), other imaging studies
(iii) Visual Acuity Reports
(iv) X-Ray
(v) Operation reports, surgical reports
(vi) Referral letters (if any)
(vii) 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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