* S U P D O C *

Singlife

Critical Illness Claim - Doctor's Statement
Coma / Coma for 48 Hours / Severe Epilepsy

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 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. tumour, stroke, diabetes, hypertension, hyperlipidaemia, hepatitis, 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** 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 give details of the patient's **alcohol consumption** habits, 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 of **First** consultation 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:

(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 **investigation** (with dates) performed for the diagnosis.
Also, please **attach** a copy of all the relevant test reports.

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

4) Is the diagnosis because of an **Accident**? ❒ Yes ❒ No

If "Yes", please advise:

(i) Date of Accident (ddmmyyyy).

(ii) Time of Accident. _____ a.m. / p.m.

(iii) Place of Accident.

(iv) Describe in detail how the accident happened.

(v) Describe the extent and severity of the brain, facial, spinal cord and/or bodily injuries/disability sustained, including exact site(s) of the body.

(vi) Was the accident reported to the police? ❒ Yes ❒ No

If "No", why not?

If "Yes", please provide the following information and **attach** a copy of the police report.
Police Division Name of Police Officer-in-charge

(vii) Did the patient have any medical condition(s) that had contributed to the accident (e.g. fits) ❒ Yes ❒ No

If "Yes", please provide details.

5) Is the diagnosis directly from:

(i) a medically induced coma? ❒ Yes ❒ No

If "Yes", please provide full details including reasons for the medically induced coma, diagnosis date, name of doctor and Hospital/Clinic who **First** diagnosed the patient with medically induced coma.

Please provide copy of test result.

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

(i) Self-inflicted act? ❒ Yes ❒ No

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

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

If "Yes", please provide full details including reasons for the self-inflicted act, 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 self-inflicted act, wilful misuse of alcohol or wilful misuse of drugs.

Please provide copy of test result.

7) How many hours was the patient in a state of coma, with no response to external stimuli? ☐ **hours**

8) Was the patient put on life support measures? ❒ Yes ❒ No

If "Yes", please advise:

(i) Date the patient was put on life support measures (ddmmyyyy)

(ii) Details of such life support measures.

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9) Had the patient emerged from the state of coma, with no response to external stimuli? ❒ Yes ❒ No

If "Yes", please advise:

(i) Date he/she emerged from the state of coma (ddmmyyyy)

(ii) Time he/she emerged from the state of coma. a.m. / p.m.

10) Was there any brain damage that resulted in permanent neurological deficit which was assessed thirty (30) days after the onset of the coma? ❒ Yes ❒ No

If "Yes", please advise:

(i) Date of the assessment (ddmmyyyy)

(ii) Details of the permanent neurological deficit and attach a copy of the report(s).

11) Has there been any improvement in the patient's condition since the onset of coma? ❒ Yes ❒ No

Please provide the basis of your evaluation.

12) Is the patient diagnosed with **Epilepsy**? ❒ Yes ❒ No

If "Yes", please advise:

(i) How was the diagnosis of Epilepsy established?

(ii) Please attach copies of diagnostic reports (i.e. Electroencephalography (EEG), Magnetic Resonance Imaging (MRI), Position Emission Tomography (PET) or other test report).

(iii) Has the patient experienced recurrent unprovoked tonic-clonic or grand mal seizures and be known to be resistant to optimal therapy as confirmed by drug serum level testing? ❒ Yes ❒ No

If "Yes", please provide:

(a) Dates of Attack (ddmmyyyy)

(b) Frequency of such attacks per week:

(iv) Is the patient taking prescribed anti-epileptic (anti-convulsant) medications recommended by a neurologist? ❒ Yes ❒ No

If "Yes", please advise:

Type(s)/Name(s) of medication prescribed	Date of commencement of medication(s) (ddmmyyyy)	Duration that the patient has taken the medication(s) till date

(v) Would you consider the patient to be an optimal drug therapy? ❒ Yes ❒ No

If "Yes", please provide the period the patient has been on such anti-epileptic therapy.

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

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

If "Yes", please advise:

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

ii) Congenital anomaly or defect? ❒ Yes ❒ No

If "Yes" for any of the above, please provide the details including diagnosis date, name of doctor and hospital/clinic where the patient was **First** diagnosed with HIV or AIDS or congenital anomaly or defect.

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

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

5) 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

6) 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

7) 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 reasonfor this course of action.

8) 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.

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

10) 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.

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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**?
If "Yes", please advise:

❒ Yes ❒ No

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

13) 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.

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) Blood test reports
(ii) Computerised tomography scan (CT scan)
(iii) Echocardiography reports
(iv) Magnetic resonance imaging (MRI), other imaging studies
(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)	