* S U P D O C *

Singlife

# Critical Illness Claim - Doctor's Statement
# Deafness (Irreversible Loss of Hearing) / Partial Loss of Hearing / Cavernous Sinus Thrombosis Surgery / Cochlear Implant Surgery

**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 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. cyst, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, anaemia, etc) If "Yes", please advise: ❒ Yes ❒ No

| 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 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:

(vii) Date of **First** Diagnosis (ddmmyyyy) | | | | | | | | |



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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
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2) Please provide full details and results of all **investigations** (with dates) performed for the diagnosis.
Also, please **attach** a copy of all the relevant test reports including audiometric, sound-threshold tests and etc.

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

4) Is there total loss of hearing in both the ears? ❒ Yes ❒ No
If "Yes", please advise:

(i) The current hearing ability in both ears (in decibels)

Right Ear _____ Left Ear _____

(ii) Please provide copies of audiogram and sound-threshold tests.

5) (i) Is there a total loss of at least 80 decibels in all frequencies of hearing in

(a) Right ear? ❒ Yes ❒ No
Date of the audiometric and sound-threshold tests results

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

(b) Left ear? ❒ Yes ❒ No
Date of the audiometric and sound-threshold tests results

| | | | | | | | |
|---|---|---|---|---|---|---|---|
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If "Yes" to (a) and/or (b), please provide supporting evidence (including audiometric and sound-threshold tests results).

(ii) Is there loss of hearing to the extent that the quietest sound that can be heard is 80 decibels or greater across all frequencies? ❒ Yes ❒ No

(iii) Is the hearing loss irreversible i.e. "cannot be reasonably restored to forty (40) decibels or lower by medical treatment, hearing aid and/or surgical procedures" in both ears? ❒ Yes ❒ No

If "No", please provide reason.



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6) (i) Is there a total loss of at least 60 decibels in all frequencies of hearing in

(a) Right ear? ❒ Yes ❒ No

Date of the audiometric and sound-threshold tests results

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

(b) Left ear? ❒ Yes ❒ No

Date of the audiometric and sound-threshold tests results

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

If "Yes" to (a) and/or (b), please provide supporting evidence (including audiometric and sound-threshold tests results).

(ii) Is the hearing loss permanent in both ears? ❒ Yes ❒ No

If "No", please provide reason.

7) Is there any surgery available that could reinstate hearing in either or both ears? ❒ Yes ❒ No

If "Yes", please advise:

(i) Nature of surgery:

(ii) What is the best possible corrected hearing frequency for both ears?

Right Ear | | Left Ear | |

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

(iv) Tentative Date of Surgery (ddmmyyyy)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

8) Is the condition resulting from drug induced partial hearing loss? ❒ Yes ❒ No

If "Yes", please provide details.



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9) Has the patient undergone **surgery for Cavemous Sinus Thrombosis**? ❒ Yes ❒ No

If "No", please proceeds to **Question 10.**

If "Yes", please advise:

(i) Date of diagnosis of Cavermous Sinus Thrombosis (ddmmyyyy) | | | | | | | | |

(ii) Was the surgery perfromed for Cavermous Sinus Thrombosis? ❒ Yes ❒ No

If "Yes", please advise:

(a) Type of Surgery performed:

(b) Date of Surgery was performed (ddmmyyyy) | | | | | | | | |

(c) Please attach copy of Operation Report and diagnostic test report.

10) Has the patient undergone **Cochlear Implant Surgery**? ❒ Yes ❒ No

If "No", please proceeds to **Section D.**

If "Yes", please advise:

(i) Was there permanent damange to the cochlea or auditory nerve? ❒ Yes ❒ No

(ii) Was Cochlear Implant Surgery performed? ❒ Yes ❒ No

If "Yes", please advise:

(a) Date of surgery (ddmmyyyy) | | | | | | | | |

(b) Was the surgery performed considered medically necessary by the ENT Specialist? ❒ Yes ❒ No

(c) Please attach copy of Operation Report.

## 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)** | | |



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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 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 state date HIV/AIDS was diagnosed (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).

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



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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 mayhave 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 reason for thiscourse 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 have 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).



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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.

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**? ❒ Yes ❒ No

If "Yes", please advise:

| 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) Audiogram & sound-threshold test reports
(ii) Cerebral angiopgraphy
(iii) Computerised tomography scan (CT scan)
(iv) Magnetic resonance imaging (MRI), other imaging studies
(v) Operation reports, surgical reports
(vi) Referral letters (if any)
(vii) Any other investigation reports



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| **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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