# Critical Illness Claim - Doctor's Statement
# HIV Due to Blood Transfusion and Occupationally Acquired HIV / HIV due to Organ Transplant and Assault

**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, hepatitis, diabetes, hypertension, hyperlipidaemia, etc.)? ❒ Yes ❒ No

If "Yes", please provide:

| 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 **AIDS / Occupationally Acquired HIV / HIV due to Blood Transfusion, Assault or Organ Transplant (please circle the appropriate 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?



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

3) Please provide the dates of all HIV and antibody tests performed and their results.

| Date of test | Name of tests | Results of tests |
|---|---|---|

4) Please provide the full details of how the patient became infected with HIV, including the date and place.

5) Did the patient become infected with Human Immunodeficiency Virus (HIV) through or resulted from:

(i) Blood Transfusion? ❒ Yes ❒ No
If "Yes", please proceed to Question 6.

(ii) Organ Transplant? ❒ Yes ❒ No
If "Yes", please proceed to Question 6.

(iii) Accident while carrying out the normal professional duties of his/her occupation in Singapore? ❒ Yes ❒ No
If "Yes", please proceed to Question 7.

(iv) Physical or sexual assault? ❒ Yes ❒ No
If "Yes", please proceed to Question 8.

6) Please provide details on the HIV infected due to **Blood Transfusion** or **Organ Transplant:**

(i) Is the organ transplant or blood transfusion medical necessary or given as part of a medical treatment? ❒ Yes ❒ No

If "Yes", please advise:

a) Reason(s) for the blood transfusion or organ transplant.

(b) Date of the transfusion or transplant (ddmmyyyy)

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

(c) What was the organ transplanted?

(ii) Please give name of doctor and address of the hospital / institution where the blood transfusion or organ transplant took place.

(iii) Is the institution that provided blood transfusion or organ transplant able to trace the origin of the HIV tainted blood? ❒ Yes ❒ No

(iv) Did the incident of infection occur in Singapore? ❒ Yes ❒ No

(v) Date on which the patient was first diagnosed HIV positive (ddmmyyyy)

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

Please proceed to **Question 9**.



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7) Please provide details on the HIV infected due to **Accident while carrying out the normal professional duties of his/her occupation in Singapore:**

(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) Was the accident reported to the appropriate authority in accordance with established occupational procedures? ❒ Yes ❒ No

If "Yes", please give details including where and when it was reported (a copy of the report is mandatory)

(vi) Was the accident involved in a definite source of the HIV infected fluids? ❒ Yes ❒ No

(vii) Is the Patient's occupation a medical practitioner, housemen, medical student, state registered nurse, medical laboratory technician, dentist (surgeon and nurse) or paramedical worker, working in medical centre or clinic (in Singapore)? ❒ Yes ❒ No

If "Yes", please advise the specific occupation:

(viii) Name of employer and address of company:

Please proceed to **Question 9**.

8) Please provide details on the HIV infected due to **Physical or sexual assault**:

(i) Date of assault (ddmmyyyy)

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

(ii) Time of assault (a.m. / p.m.)

(iii) Place of assault:

(vi) Describe in detail how the assault happened.

(v) Date the assault was reported to the appropriate authority (ddmmyyyy)

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

(vi) Name of the authority

(vii) Whether a criminal case has been opened? ❒ Yes ❒ No

If "Yes", please attach a copy of the report/evidence.

(viii) Was the assault involved in a definite source of the HIV infected fluids? ❒ Yes ❒ No

Please proceed to **Question 9**.



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9) Is there evidence of HIV infection due to other means such as sexual activity, use of intravenous drugs?

❒ Yes ❒ No

If "Yes", please provide the exact causes and date of the HIV infection.

10) Is there evidence of seroconversion from HIV negative to HIV positive occurring for 180 days after the documented **Accident while carrying out the normal professional duties of his/her occupation in Singapore** or **physical or sexual assault**? ❒ Yes ❒ No

If "Yes", please provide full details, including test results and a copy of test results.

11) Is there a negative HIV antibody test conducted within 5 days from the documented **Accident while carrying out the normal professional duties of his/her occupation in Singapore** or **physical or sexual assault**? ❒ Yes ❒ No

If "Yes", please provide full details, including test results and a copy of test results.

12) Was the source of the infection established? ❒ Yes ❒ No

If "Yes", please provide full details of the definite source of (a) HIV tainted blood, (b) infected transplanted organ and/or (c) infected fluids, test results and a copy of test results (*Please* ***circle*** *the appropriate condition)*.

13) Is the patient suffering from:

(i) Thalassaemia major? ❒ Yes ❒ No

(ii) Haemophilia? ❒ Yes ❒ No

If "Yes" to (i) or (ii), please provide details as follows:

(a) Date of diagnosis (ddmmyyyy) | | | | | | | | |

(b) Name of doctors and address of hospitals / institutions consulted.

(c) Nature of tests performed, date of tests performed and their results.

| Date of test | Name of tests | Results of tests |
|---|---|---|



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14) Is there any treatment that renders the HIV inactive or non-infectious? ❒ Yes ❒ No

If "Yes", please provide details.

15) Please provide details of **investigation** performed and **attach** a copy of the test results/reports.

16) Has a cure for AIDS / HIV become available prior to the time the patient is being infected? ❒ Yes ❒ No

If "Yes", please provide details.

17) Please provide details of **treatment**.

18) Was the patient admitted to a hospital for treatment of the condition? ❒ 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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19) Was the patient admitted to Intensive Care Unit (ICU) for treatment of the condition? ❒ 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)** | | |

## D) Other Information

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

   i) Wilful misuse of alcohol? ❒ Yes ❒ No

   ii) Wilful misuse of drugs? ❒ Yes ❒ No

   iii) 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 who **First** diagnosed the patient with wilful misuse of alcohol, wilful misuse of drugs or congenital anomaly or defect.

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

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

3) Has the patient ever been hospitalised for the **AIDS / HIV infection** or its related symptoms or complications? If "Yes", please advise: ❒ Yes ❒ No

| Date of hospitalisation | Reasons for hospitalisation | Treatment received (including operation, if any) | Name of doctor/surgeon & Address of hospital |
|---|---|---|---|

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

If "Yes", please advise:

| Type of Lifestyle/Exact diagnosis | Age of diagnosis | Relationship with patient (if applicable) | Name of doctor & address of hospital/clinic |
|---|---|---|---|
| | | | |

5) Is there anything in the patient's **family history** that mayhave increased the risk of this condition? ❒ Yes ❒ No

If "Yes", please advise:

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

6) 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.

7) 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 provide:

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.

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

9) 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.

10) (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

11) 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 provide:

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

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

If "Yes", please advise date of next appointment (ddmmyyyy)

If "No", please state date of discharge (ddmmyyyy), if any.

13) 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, laboratory reports that are available. Where applicable, pleace include the following:

(i) Blood test reports
(ii) HIV test reports
(iii) Operation reports, surgical reports
(iv) Referral letters (if any)
(v) 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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