



Critical Illness Claim - Doctor's Statement
Major Head Trauma / Facial Reconstructive Surgery / Cervical Spinal Cord Injury /
Intermediate Stage Major Head Trauma

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) <table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>								

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)	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>								
(ii) Date of Last consultation (ddmmyyyy)	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>								
(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?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
If "Yes", since when? (ddmmyyyy)	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>								
If "No", please provide name and address of the patient's regular doctor.									

3) Was the patient referred to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
If "Yes", please advise:									
(i) Date referred (ddmmyyyy)	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>								
(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?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(i) Date referred (ddmmyyyy)	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>								
(ii) Reason for referral:									
(iii) Name and address of doctor referred to:									

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 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 the patient **First** consulted you for the condition (ddmmyyyy)

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

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

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(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)		<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>										
(viii)	Date the patient First became aware of the illness/condition (ddmmyyyy)		<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>										
2) Please provide full details and results of all investigation(s) (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 ? <input type="checkbox"/> Yes <input type="checkbox"/> No													
If "Yes", please advise:													
(i)	Date of Accident (ddmmyyyy)		<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>										
(ii)	Time of Accident	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 100px; height: 20px;"></td> </tr> </table>		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? If "No", why not?	<input type="checkbox"/> Yes <input type="checkbox"/> No											
If "Yes", please provide the following information and attach a copy of the police report.													
<u>Police Division</u>		<u>Name of Police Officer-in-charge</u>											
(vii)	Did the patient have any medical condition(s) that had contributed to the accident (e.g. fits) If "Yes", please provide full details.	<input type="checkbox"/> Yes <input type="checkbox"/> No											

(viii) Did the patient have any medical condition(s) that had contributed to the accident (e.g. fits) Yes No
 If "Yes", please provide full details.

5) Is the diagnosis directly or indirectly, wholly, or partly caused by, 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 a copy of the relevant test result(s).

6) 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)		

7) 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)		

8) Did the patient refuse any form of medical treatment, including surgery, which might have prevented or reduced the severity of the impairment? Yes No

If "Yes", please provide full details.

9) If the patient had suffered from

- (i) Major Head Trauma, please proceed to **Section D**.
- (ii) Facial Injury, proceed to **Section E**.
- (iii) Cervical Spinal Cord Injury, proceed to **Section F**.

D) This section is applicable for Major Head Trauma only.

1) Describe the exact nature of the brain injury.

(As the policy specifies that the brain injury must be demonstrated by a modern scanning or imaging techniques, please **attach** a copy of the Magnetic Resonance Imaging or Computerised Tomography Scan.)

2) Was the patient diagnosed of:

(i) head injury?

Yes No

(ii) spinal cord injury?

Yes No

(iii) head injury due to other cause?

Yes No

If yes, please advise the cause:

3) Was there any form of neurological deficit still present 6 weeks after the date of the accident? Yes No
If "Yes", please advise:

(i) Full details of the neurological deficits.

(ii) **Date of Last review** confirming the neurological deficit (ddmmyyyy)

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4) Is the neurological deficit permanent and expected to last throughout the lifetime of the patient? Yes No

If "No", please state the date of recovery *or* date for which the patient is expected to recover from the neurological deficit (ddmmyyyy)

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If "Yes", please provide details:

5) Name and address of the neurologist who **First** diagnosed the patient with Major Head Trauma.

6) Was there any surgery done? Yes No

If "Yes", please advise:

(i) Date of surgery (ddmmyyyy)

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(ii) Nature or type of the surgery performed (e.g. open craniotomy, burr hole surgery, etc.)

(iii) Did the patient undergo open craniotomy?

Yes No

If "Yes", was it due to consequence of

a) major head trauma for the treatment of depressed skull fractures?

Yes No

b) major intracranial injury?

Yes No

(iv) Did the patient undergo burr hole surgery?

Yes No

Please provide copy of operation report and surgery note.

7) Please provide details of current **treatment**, including any physical and speech therapy, if any.

E) This section is applicable to Facial Reconstructive Surgery only.

1) Was there any reconstructive surgery above the neck (restoration or reconstruction of the shape of, and appearance of facial structures which were defective, missing or damaged or misshapen) to correct disfigurement as a direct result of the accident? Yes No

If "Yes", please advise:

(i) Date of surgery performed (ddmmyyyy)

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(ii) Was the reconstructive surgery solely for treatment relating to

a) teeth?

Yes No

b) any other dental restoration alone?

Yes No

c) cosmetic nose surgery?

Yes No

Please provide copy of operation report and surgery note.

2) Name and address of the specialist who performed the surgery.

F) This section is applicable to Cervical Spinal Cord Injury only.

1) Describe the exact nature of the cervical spinal cord injury.
(As the policy specifies that the said injury must be demonstrated by a modern scanning or imaging techniques, please **attach** a copy of the Magnetic Resonance Imaging or Computerised Tomography Scan.)

2) Has the accidental cervical spinal cord injuries resulted in the loss of use of at least one entire limb for at least 6 weeks? Yes No

If "Yes", please advise:

(i) Full details of the loss of use of the limb.

(ii) **Date of Last review** confirming the the loss of use of at least one entire limb (ddmmyyyy)

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G) 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?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", please advise:			
<u>Type of Lifestyle / Exact diagnosis</u>	<u>Date of diagnosis</u>	<u>Name of doctor & Address of hospital/clinic</u>	
3) Is there anything in the patient's family history that may have increased the risk of the condition?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", please advise:			
<u>Relationship with patient</u>	<u>Nature of condition</u>	<u>Age of onset</u>	<u>Source of information</u>
4) Have active treatment and therapy been rejected in favour of the relief of symptoms? If "Yes", please provide full details and explain the reason for this course of action.			<input type="checkbox"/> Yes <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(ii)	Twelve (12) months?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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:

<u>Name of doctor and Address of hospital/clinic</u>	<u>Date of First & Last consultation</u>	<u>Reasons for consultation</u>

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

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

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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 into assessing this claim.

Please enclose copies of all investigation reports including specialist, hospital and laboratory reports. Where applicable, please provide the following:

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

H) Declaration

I hereby declare that the above answers are true to the best of my knowledge and belief.

Signature of Doctor

Address & Official Stamp of Doctor

Name of Doctor

Date (ddmmyyyy)