



Critical Illness Claim – Doctor’s Statement Major Burns / Mild Burns

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" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></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" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>								
(ii) Date of Last consultation (ddmmyyyy)	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></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" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></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" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>								
(ii) Reason the patient was referred:									
(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" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></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, 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 the patient **First** consulted you for the condition (ddmmyyy)

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

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

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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 (ddmmyyy)

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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 **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 diagnosis.

4) Is the diagnosis because of an **Accident**?
If "Yes", please advise:

Yes No

(i) Date of Accident (ddmmyyyy):

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(ii) Time of Accident:

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 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?

Yes No

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)
If "Yes", please provide full details.

Yes No

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 copy of test result.

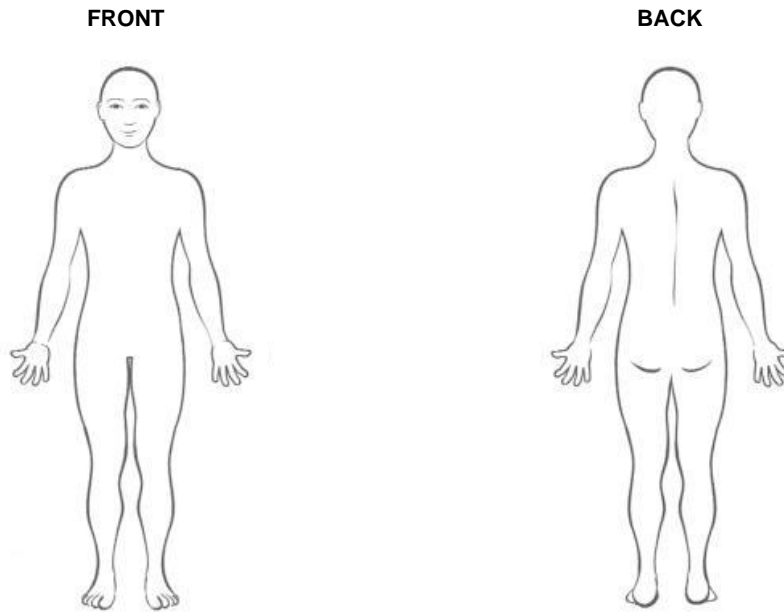
6) Please state the areas affected on the patient's body, the percentage of surface area, and the degree of burns in each affected area:

Areas affected	Percentage of surface area	Degree of burns

Please advise the following:

- a) Is the patient suffering from a third degree (full thickness of the skin) burns covering at least 20% of the surface of the body? Yes No
- b) Is the patient suffering from a second degree (partial thickness of the skin) burns covering at least 20% of the surface of the body? Yes No
- c) Is the patient suffering from a third degree (full thickness of the skin) burns covering at least 50% of the face? Yes No

7) Please circle (in blue) the areas affected by burns in the picture below, and attach a copy of any relevant hospital reports such as the Burns report.



8) Please provide full details of **treatment** received, including any skin grafts to repair damaged skin (past and/or contemplated).

9) 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 (ddmmyyy; hh:mm)		
Discharge Date and Time (ddmmyyy; hh:mm)		
Name of the hospital		
Admission Date and Time (ddmmyyy; hh:mm)		
Discharge Date and Time (ddmmyyy; 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)		

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 accidents or burns, including congenital anomaly or defects? Yes No

If "Yes", please advise:

Type of Lifestyle/Exact diagnosis

Date of diagnosis

Name of doctor & address of hospital/clinic

3) Is there anything in the patient's **family history** which would have increased the risk of accidents or burns? Yes No

If "Yes", please advise:

Relationship with patient

Nature of condition

Age of onset

Source of information

4) 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.

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 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 will enable the Company to assess this claim.

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

- (i) Operation reports, surgical reports
- (ii) Referral letters (if any)
- (iii) 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 & Official Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	