



Critical Illness Claim - Doctor's Statement Multiple Sclerosis / Early Multiple Sclerosis

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 for the 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" 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. cyst, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, frequent falls, etc.) If "Yes", please advise:	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; border-bottom: 1px solid black;"><u>Details of symptoms</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Exact diagnosis</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Date diagnosed</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Treatment</u></td> </tr> </table>	<u>Details of symptoms</u>	<u>Exact diagnosis</u>	<u>Date diagnosed</u>	<u>Treatment</u>	
<u>Details of symptoms</u>	<u>Exact diagnosis</u>	<u>Date diagnosed</u>	<u>Treatment</u>		
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.					
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border-bottom: 1px solid black;"><u>No. of years of smoking</u></td> <td style="width: 33%; border-bottom: 1px solid black;"><u>No. of sticks per day</u></td> <td style="width: 34%; border-bottom: 1px solid black;"><u>Source of information</u></td> </tr> </table>	<u>No. of years of smoking</u>	<u>No. of sticks per day</u>	<u>Source of information</u>		
<u>No. of years of smoking</u>	<u>No. of sticks per day</u>	<u>Source of information</u>			
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.					
<table style="width: 100%; border: none;"> <tr> <td style="width: 30%; border-bottom: 1px solid black;"><u>Type of alcohol</u></td> <td style="width: 20%; border-bottom: 1px solid black;"><u>Quantity per Consumption</u></td> <td style="width: 30%; border-bottom: 1px solid black;"><u>Frequency</u> (per week / month, etc.)</td> <td style="width: 20%; border-bottom: 1px solid black;"><u>Source of information</u></td> </tr> </table>	<u>Type of alcohol</u>	<u>Quantity per Consumption</u>	<u>Frequency</u> (per week / month, etc.)	<u>Source of information</u>	
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C) Details of Illness											
1) Please provide details of the condition:											
(i) Date the patient First consulted you for the condition (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> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
(ii) Details of symptom(s) presented at First consultation.											
(iii) Date of onset of these symptoms (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> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
(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="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>								
(viii) Date the patient First became aware of the illness/condition (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>								
<p>2) Please provide full details and results of all investigation performed (with dates) performed for the diagnosis. Also, please attach a copy of all the relevant test reports including magnetic resonance imaging, evoked potentials, cerebrospinal fluid analysis etc.</p>									
<p>3) Name and address of the doctor who First diagnosed the patient with Multiple Sclerosis.</p>									
<p>4) Please describe in full details (with dates) the extent of neurological deficits.</p>									
<p>5) Based on the Last consultation, the multiple neurological deficits (described in Question 4) have occurred over a continuous period of</p> <p>(i) At least 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(ii) At least _____ months? (please specific the number of months) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please support with evidence including dates of each episode.</p>									
<p>6) Is there a well-documented history of exacerbations and remissions of the said symptoms or neurological deficits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes", please advise:</p> <p>(i) Dates of history (ddmmyyyy)</p>									

- 7) Are the neurological deficits/damage due to:
- (i) Systemic Lupus Erythematosus ("SLE")? Yes No
- (ii) Human Immunodeficiency Virus ("HIV")? Yes No
- (iii) Others (please specify): Yes No
- If "Yes", please provide details.

8) Please provide details of current **treatment**, including name and dosage of medication, operation contemplated (if any).

- 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 (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)		

- 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)		

11) 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) or Acquired Immune Deficiency Syndrome (AIDS) infection? Yes No

If "Yes", please advise:

Date of Diagnosis of AIDS/HIV (ddmmyyyy)

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

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- (ii) wilful misuse of drugs? Yes No
- (iii) wilful misuse of alcohol? Yes No
- (iv) congenital anomaly or defect? Yes No

If "Yes" for any of the above, please provide the details including 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 drugs, wilful misuse of alcohol or congenital anomaly or defect.

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

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 the condition? 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** 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

<p>4) Have active treatment and therapy now been rejected in favour of relief of symptoms? If "Yes", please provide full details and explain the reason for this course of action.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No			
<p>5) Based on the Last consultation and despite all reasonable medical treatment, is the condition highly likely to lead to death within the next:</p> <p>(i) Six (6) months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(ii) Twelve (12) months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes" to (i) and/or (ii), please advise:</p> <p>a) Medical treatment(s) that had been provided to the patient</p> <p>b) Prognosis after undergoing the mentioned medical treatment(s)</p> <p>c) Any other details on the basis of your evaluation.</p>				
<p>6) Please describe and elaborate on the nature and severity of the patient's physical disability and limitation(s).</p>				
<p>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.</p>				
<p>8) (i) Is the patient mentally incapacitated? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(ii) If the patient is mentally incapacitated, is he/she mentally capable of receiving or handling money? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>				
<p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes", please advise:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><u>Name of doctor and Address of hospital/clinic</u></td> <td style="width: 33%;"><u>Date of First & Last consultation</u></td> <td style="width: 33%;"><u>Reasons for consultation</u></td> </tr> </table>		<u>Name of doctor and Address of hospital/clinic</u>	<u>Date of First & Last consultation</u>	<u>Reasons for consultation</u>
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10) Is the patient still on follow-up at your hospital/clinic?

Yes No

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

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

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11) 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) Cerebrospinal fluid analysis results
- (iii) Computerised tomography scan (CT scan)
- (iv) Evoked potentials results
- (v) Magnetic resonance imaging (MRI), other imaging studies
- (vi) Operation reports, surgical reports
- (vii) Referral letters (if any)
- (viii) 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 (ddmmyyy)	