



Critical Illness Claim - Doctor's Statement
Muscular Dystrophy / Spinal Cord Disease or Injury resulting in Bowel and Bladder Dysfunction /
Moderate Muscular Dystrophy

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 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. scoliosis, tumour, stroke, diabetes, hypertension, hyperlipidaemia, 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: 25%; border-bottom: 1px solid black;"><u>Type of alcohol</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Quantity per Consumption</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Frequency (per week / month, etc)</u></td> <td style="width: 25%; 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 (per week / month, etc)</u>	<u>Source of information</u>							
<u>Type of alcohol</u>	<u>Quantity per Consumption</u>	<u>Frequency (per week / month, etc)</u>	<u>Source of information</u>								
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="border-collapse: collapse; width: 100%;"> <tr> <td style="width: 12.5%; height: 20px;"></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 during the First consultation.											
(iii) Date of onset of these symptoms (ddmmyyyy)	<table border="1" style="border-collapse: collapse; width: 100%;"> <tr> <td style="width: 12.5%; height: 20px;"></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>								
2) Was the diagnosis of muscular dystrophy confirmed by muscular biopsy? If "Yes", please advise:	<input type="checkbox"/> Yes <input type="checkbox"/> No								
Date of muscular biopsy (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>								
Details of the muscular biopsy:									
If "No", please advise on the clinical basis for the diagnosis of muscular dystrophy.									
3) Please provide full details and results of all investigation (with dates) performed for the diagnosis. Also, please attach a copy of all relevant test reports including muscle biopsy, electromyogram, enzyme tests such as creatine kinase etc.									
4) Name and address of the Neurologist who First diagnosed the patient with the condition.									
5) Please describe in detail (with dates) the extent of neurological deficits suffered by the patient.									
6) Are there signs of progressive impairment? If "Yes", please elaborate (with dates) on how the condition has deteriorated over time.	<input type="checkbox"/> Yes <input type="checkbox"/> No								
7) Is the diagnosis a									
(i) Spinal cord disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(ii) Chorda equina injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
If "Yes", please advise:									
(a) Details on the above condition.									

(b) Has the above condition resulted in permanent bowel dysfunction and bladder dysfunction?

Yes No

If "Yes", please advise:

(i) Is the following treatment required for the permanent bowel dysfunction and bladder dysfunction?

a) Permanent regular self-catheterisation

Yes No

b) Permanent urinary conduit

Yes No

(ii) Has the permanent bowel and bladder dysfunction requiring permanent regular self-catheterisation or a permanent urinary conduit lasted for at least six (6) months?

Yes No

If "Yes", please advise:

Date of permanent bowel and bladder dysfunction
requiring above treatment **First** started (ddmmyyyy)

--	--	--	--	--	--	--	--	--	--

8) Please provide details of current **treatment** received for Muscular Dystrophy, including the 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 patient's 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 provide details:

Date of Diagnosis of AIDS/HIV (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).

D) Additional Information

1) Based on the **Last consultation mentioned on Section B 1ii) above**, please **circle as applicable** in relation to the patient's ability to perform the Activities of Daily Living (ADLs), whether aided or unaided by special equipment, device and/or apparatus (and not pertaining to human aid).

Definition of ADL	Extent of Independence	Yes / No	If patient always requires another person's help, please state the followings:								
<p>Washing/Bathing: The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.</p>	<ul style="list-style-type: none"> • Able to perform independently and without any assistance. • Able to perform with aid of special equipment. <p>Always require another person's assistance throughout the entire activity.</p>	<p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p>	<p>(a) Reasons</p> <p>_____</p> <p>_____</p> <p>(b) Date of disability First occurred (ddmmyyyy)</p> <table border="1" data-bbox="950 619 1383 676"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table> <p>(c) For how long has he/she been continuously unable to do so?</p> <p>_____</p>								
<p>Dressing: The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.</p>	<ul style="list-style-type: none"> • Able to perform independently and without any assistance. • Able to perform with aid of special equipment. <p>Always require another person's assistance throughout the entire activity.</p>	<p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p>	<p>(a) Reasons</p> <p>_____</p> <p>_____</p> <p>(b) Date of disability First occurred (ddmmyyyy)</p> <table border="1" data-bbox="950 1102 1383 1159"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table> <p>(c) For how long has he/she been continuously unable to do so?</p> <p>_____</p>								
<p>Transferring: The ability to move from a bed to an upright chair or wheelchair and vice versa.</p>	<ul style="list-style-type: none"> • Able to perform independently and without any assistance. • Able to perform with aid of special equipment. <p>Always require another person's assistance throughout the entire activity.</p>	<p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p>	<p>(a) Reasons</p> <p>_____</p> <p>_____</p> <p>(b) Date of disability First occurred (ddmmyyyy)</p> <table border="1" data-bbox="950 1585 1383 1642"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table> <p>(c) For how long has he/she been continuously unable to do so?</p> <p>_____</p>								

<p>Mobility: The ability to move indoors from room to room on level surfaces.</p>	<ul style="list-style-type: none"> • Able to perform independently and without any assistance. • Able to perform with aid of special equipment. <p>Always require another person's assistance throughout the entire activity.</p>	<p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p>	<p>(a) Reasons</p> <p>_____</p> <p>_____</p> <p>(b) Date of disability First occurred (ddmmyyyy)</p> <table border="1" data-bbox="951 396 1383 453"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table> <p>(c) For how long has he/she been continuously unable to do so?</p> <p>_____</p>								
<p>Toileting: The ability to use the lavatory or otherwise manage bowel and bladder functions to maintain a satisfactory level of personal hygiene.</p>	<ul style="list-style-type: none"> • Able to perform independently and without any assistance. • Able to perform with aid of special equipment. <p>Always require another person's assistance throughout the entire activity.</p>	<p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p>	<p>(a) Reasons</p> <p>_____</p> <p>_____</p> <p>(b) Date of disability First occurred (ddmmyyyy)</p> <table border="1" data-bbox="951 831 1383 888"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table> <p>(c) For how long has he/she been continuously unable to do so?</p> <p>_____</p>								
<p>Feeding: The ability to feed oneself once food has been prepared and made available.</p>	<ul style="list-style-type: none"> • Able to perform independently and without any assistance. • Able to perform with aid of special equipment. <p>Always require another person's assistance throughout the entire activity.</p>	<p>Yes / No</p> <p>Yes / No</p> <p>Yes / No</p>	<p>(a) Reasons</p> <p>_____</p> <p>_____</p> <p>(b) Date of disability First occurred (ddmmyyyy)</p> <table border="1" data-bbox="951 1268 1383 1325"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table> <p>(c) For how long has he/she been continuously unable to do so?</p> <p>_____</p>								
<p>2) What tests or assessments were used to evaluate the patient's functional ability for each of the ADLs (e.g. standardised functional assessments, observation of patient performing ADL-specific tasks, etc.)?</p>											

3)	If your assessment of the patient's function for each of the ADLs was taken from report(s) provided by the patient or relatives, please attach a copy of relevant report(s).	
4)	What is the prognosis of the patient's condition?	
5)	Is there anything in the patient's lifestyle or personal medical history that may have increased the patient's risk of suffering from 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>	
6)	Is there anything in the patient's family history that may have increased the patient's risk of suffering from 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>	
7)	Have active treatment and therapy now been rejected in favour of relief of symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide full details and explain the reason for this course 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? <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.	

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

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:

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

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) Computerised tomography scan (CT scan)
- (ii) Electromyography reports
- (iii) Magnetic resonance imaging (MRI), other imaging studies
- (iv) Muscular Biopsy
- (v) Operation reports, surgical reports
- (vi) Referral letters (if any)
- (vii) 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)