



**Critical Illness Claim - Doctor's Statement  
Idiopathic Parkinson's Disease / Early Parkinson's Disease /  
Moderately Severe Parkinson's Disease**

**DOCTOR'S STATEMENT** (to be completed by the attending doctor at claimant's expense)

<b>A) Patient's Particulars</b>									
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>B) Patient's Medical Records</b>									
1) Please indicate the period that is documented in the hospital/clinic's record:									
(i) Date of <b>First</b> 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 <b>Last</b> 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? <span style="float:right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>									
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? <span style="float:right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>									
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? <span style="float:right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>									
(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, stroke, diabetes, hypertension, hyperlipidaemia, hepatitis, obesity, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No				
If "Yes", please advise: <table style="width: 100%; border: none;"> <tr> <td style="border: none;"><u>Details of symptoms</u></td> <td style="border: none;"><u>Exact diagnosis</u></td> <td style="border: none;"><u>Date diagnosed</u></td> <td style="border: none;"><u>Treatment</u></td> </tr> </table>		<u>Details of symptoms</u>	<u>Exact diagnosis</u>	<u>Date diagnosed</u>	<u>Treatment</u>
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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 <b>smoking</b> 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="border: none;"><u>No. of years of smoking</u></td> <td style="border: none;"><u>No. of sticks per day</u></td> <td style="border: none;"><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 <b>alcohol consumption</b> habits, including the amount of the alcohol consumption, frequency, and the source of this information.					
<table style="width: 100%; border: none;"> <tr> <td style="border: none;"><u>Type of alcohol</u></td> <td style="border: none;"><u>Quantity per Consumption</u></td> <td style="border: none;"><u>Frequency (per week / month, etc)</u></td> <td style="border: none;"><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>
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<b>C) Details of Illness</b>									
1) Please provide details of the condition:									
(i) Date the patient <b>First</b> 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> </tr> </table>								
(ii) Details of symptom(s) presented during the <b>First</b> 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> </tr> </table>								
(iv) What is/are the underlying cause(s) of the symptoms?									
(v) <b>Final</b> Diagnosis of the condition:									
(vi) ICD-10 Code:									
(vii) Date of <b>First</b> 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 <b>First</b> became aware of the illness/condition (ddmmyyyy)	<table border="1" style="width: 100%; height: 25px; 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) Please provide full details and results of all <b>investigation</b> (with dates) performed for the diagnosis. Also, please <b>attach</b> a copy of all relevant test reports.													
3) Name and address of the <b>Neurologist</b> who <b>First</b> diagnosed the patient with the condition.													
4) Please describe in detail the extent of neurological deficits suffered by the patient (with dates).													
5) Please advise if the Parkinson's Disease is: <table style="width: 100%; margin-top: 10px;"> <tr> <td style="width: 70%;">(i) Idiopathic in nature</td> <td style="width: 10%; text-align: center;"><input type="checkbox"/> Yes</td> <td style="width: 20%; text-align: center;"><input type="checkbox"/> No</td> </tr> <tr> <td>(ii) Toxin-caused</td> <td style="text-align: center;"><input type="checkbox"/> Yes</td> <td style="text-align: center;"><input type="checkbox"/> No</td> </tr> <tr> <td>(iii) Drug-induced (e.g. resulted from treatment for any other illness, etc.)</td> <td style="text-align: center;"><input type="checkbox"/> Yes</td> <td style="text-align: center;"><input type="checkbox"/> No</td> </tr> <tr> <td>(iv) Associated with any other disease (e.g. Wilson's disease or Huntington's Chorea)</td> <td style="text-align: center;"><input type="checkbox"/> Yes</td> <td style="text-align: center;"><input type="checkbox"/> No</td> </tr> </table> <p style="margin-top: 10px;">If "Yes" to any of the above, please elaborate including date of diagnosis, name and address of the <b>Neurologist</b> who made the diagnosis and source of information.</p>		(i) Idiopathic in nature	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(ii) Toxin-caused	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(iii) Drug-induced (e.g. resulted from treatment for any other illness, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(iv) Associated with any other disease (e.g. Wilson's disease or Huntington's Chorea)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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(ii) Toxin-caused	<input type="checkbox"/> Yes	<input type="checkbox"/> No											
(iii) Drug-induced (e.g. resulted from treatment for any other illness, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No											
(iv) Associated with any other disease (e.g. Wilson's disease or Huntington's Chorea)	<input type="checkbox"/> Yes	<input type="checkbox"/> No											
6) Please provide details of current <b>treatment</b> received for Parkinson's disease, including the name and dosage of medication, operation contemplated (if any)?													
7) Can the condition be controlled with medication? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>													
If "Yes", please state date the medical treatment <b>First</b> started (ddmmyyyy)	<table border="1" style="width: 100%; height: 25px; 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>												

8) Are there signs of progressive impairment?

Yes  No

If "Yes", please elaborate (with dates) on how the condition has deteriorated over time.

9) Was the patient admitted to a hospital for treatment of the diagnosis?

Yes  No

If "Yes", please advise:

<b>Name of the hospital</b>		
<b>Admission Date and Time (ddmmyyyy; hh:mm)</b>		
<b>Discharge Date and Time (ddmmyyyy; hh:mm)</b>		
<b>Name of the hospital</b>		
<b>Admission Date and Time (ddmmyyyy; hh:mm)</b>		
<b>Discharge Date and Time (ddmmyyyy; hh:mm)</b>		

10) Was the patient admitted to Intensive Care Unit (ICU) for treatment of the diagnosis?

Yes  No

If "Yes", please advise:

<b>Name of the hospital</b>		
<b>Admission Date and Time (ddmmyyyy; hh:mm)</b>		
<b>Discharge Date and Time (ddmmyyyy; hh:mm)</b>		
<b>Name of the hospital</b>		
<b>Admission Date and Time (ddmmyyyy; hh:mm)</b>		
<b>Discharge Date and Time (ddmmyyyy; hh:mm)</b>		

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):

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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 <u>always requires</u> another person's help, please state the followings:								
<p><b>Washing /Bathing:</b> 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"> <li>• Able to perform independently and without any assistance.</li> <li>• Able to perform with aid of special equipment.</li> <li>• Always require another person's assistance throughout the entire activity.</li> </ul>	<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 <b>First</b> occurred (ddmmyyyy)</p> <table border="1"> <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><b>Dressing:</b> 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"> <li>• Able to perform independently and without any assistance.</li> <li>• Able to perform with aid of special equipment.</li> <li>• Always require another person's assistance throughout the entire activity.</li> </ul>	<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 <b>First</b> occurred (ddmmyyyy)</p> <table border="1"> <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><b>Transferring:</b> The ability to move from a bed to an upright chair or wheelchair and vice versa.</p>	<ul style="list-style-type: none"> <li>• Able to perform independently and without any assistance.</li> <li>• Able to perform with aid of special equipment.</li> <li>• Always require another person's assistance throughout the entire activity.</li> </ul>	<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 <b>First</b> occurred (ddmmyyyy)</p> <table border="1" data-bbox="948 407 1382 464"> <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><b>Mobility:</b> The ability to move indoors from room to room on level surfaces.</p>	<ul style="list-style-type: none"> <li>• Able to perform independently and without any assistance.</li> <li>• Able to perform with aid of special equipment.</li> <li>• Always require another person's assistance throughout the entire activity.</li> </ul>	<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 <b>First</b> occurred (ddmmyyyy)</p> <table border="1" data-bbox="948 814 1382 871"> <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><b>Toileting:</b> 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"> <li>• Able to perform independently and without any assistance.</li> <li>• Able to perform with aid of special equipment.</li> <li>• Always require another person's assistance throughout the entire activity.</li> </ul>	<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 <b>First</b> occurred (ddmmyyyy)</p> <table border="1" data-bbox="948 1224 1382 1281"> <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><b>Feeding:</b> The ability to feed oneself once food has been prepared and made available.</p>	<ul style="list-style-type: none"> <li>• Able to perform independently and without any assistance.</li> <li>• Able to perform with aid of special equipment.</li> <li>• Always require another person's assistance throughout the entire activity.</li> </ul>	<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 <b>First</b> occurred (ddmmyyyy)</p> <table border="1" data-bbox="948 1659 1382 1715"> <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>								

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.)?	
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 <b>lifestyle</b> or <b>personal medical history</b> that may have increased the patient's 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 &amp; Address of hospital/clinic</u>	
6)	Is there anything in the patient's <b>family history</b> that may have increased the patient's 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>
7)	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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
8)	Based on the <b>Last</b> 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).

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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.

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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

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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 &amp; Last consultation</u>	<u>Reasons for consultation</u>

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13) 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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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) Histological Report
- (iii) Magnetic resonance imaging (MRI), other imaging studies
- (iv) Operation reports, surgical reports
- (v) Referral letters (if any)
- (vi) 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)	