



**Critical Illness Claim - Doctor's Statement  
Poliomyelitis / Moderately Severe Poliomyelitis**

**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"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></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"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>								
(ii) Date of <b>Last</b> 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", how did the patient come 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 provide 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 provide 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) <b>Final</b> Diagnosis of the condition:									
(vi) ICD-10 Code:									
(vii) Date of <b>First</b> 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> </tr> </table>								
(viii) Date the patient <b>First</b> 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> </tr> </table>								
2) What was the cause of the patient's Poliomyelitis (e.g. spinal polio, bulbo-spinal polio, Poliovirus etc.)? Please elaborate:									
3) Please advise the name of the specialist and address of the hospital who made the diagnosis of Poliomyelitis?									
4) Please provide full details and results of all <b>investigations</b> (with dates) performed for the diagnosis. Also, please <b>attach</b> a copy of all the relevant test reports:									
5) Please describe the extent of the patient's paralysis from poliomyelitis:									
6) Is there paralysis of the patient's limb muscles? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>									
If "Yes", please advise on the following:									
(i) Has it been present and persist for at least 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(ii) Date of onset of impaired motor function (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> </tr> </table>								
(iii) The full details of the impaired motor function:									
Please attach a copy of the medical documentation.									

7) Is there paralysis of the patient's respiratory muscles?

Yes  No

If "Yes", please advise on the following:

(i) Has it been present and persist for at least 3 months?

Yes  No

(ii) Date of onset of respiratory weakness (ddmmyyyy):

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(iii) The full details of the respiratory weakness:

Please attach a copy of the medical documentation.

8) If there is paralysis of the patient's respiratory muscles, is there support by ventilator for a continuous period of minimum 96 hours?

Yes  No

If "Yes", please advise on the following:

(i) Date of ventilator started (ddmmyyyy):

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9) Please provide full details of the treatment received, including the date(s) (e.g. name of medication, type of surgery, therapy, etc.):

10) Was the patient admitted at the 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>		

11) 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>		

12) 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 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 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 the relevant of test result(s).

**D) Other Information**

1) What is the prognosis of the patient's condition?

<p>2) Is there anything in the patient's <b>lifestyle</b> or <b>personal medical history</b> that may have increased the risk of the condition? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>If "Yes", please advise:</p> <p style="margin-left: 20px;"> <u>Type of Lifestyle / Exact diagnosis</u>                      <u>Date of diagnosis</u>                      <u>Name of doctor &amp; Address of hospital/clinic</u> </p>
<p>3) Is there anything in the patient's <b>family history</b> that may have increased the risk of the condition? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>If "Yes", please advise:</p> <p style="margin-left: 20px;"> <u>Relationship with patient</u>                      <u>Nature of condition</u>                      <u>Age of onset</u>                      <u>Source of information</u> </p>
<p>4) Have active treatment and therapy now been rejected in favour of relief of symptoms? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>If "Yes", please provide full details and explain the reason for this course of action.</p>
<p>5) 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:</p> <p>(i) Six (6) months? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>(ii) Twelve (12) months? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></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 <b>physical</b> disability and limitation(s).</p>
<p>7) Please describe and elaborate on the nature and severity of the patient's <b>mental</b> disability and limitation(s), including the degree of cognitive and/or intellectual impairment.</p>

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 **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 <b>First &amp; Last</b> 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 advise 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 all investigation reports including specialist, hospital and laboratory reports. Where applicable, please include the following:

- (i) Blood test reports
- (ii) Computerised tomography scan (CT scan)
- (iii) Magnetic resonance imaging (MRI), other imaging studies
- (iv) X-Ray
- (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)	