



**Critical Illness Claim - Doctor's Statement  
Progressive Scleroderma / Early Progressive Scleroderma /  
Systemic Sclerosis with CREST Syndrome**

**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, hepatitis, 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="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>							
<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 provide details of the patient's past and present <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 provide 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 <b>Scleroderma</b> :											
(i) Date the patient <b>First</b> consulted you for this 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 <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> <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:

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(vi) ICD-10 Code:

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(vii) Date of **First** diagnosis (ddmmyyy) 

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(viii) Date the patient **First** became aware of the illness/condition (ddmmyyy): 

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(ix) Is the diagnosis of **Scleroderma** causing any of the following?

(a) Progressive diffuse fibrosis in the skin  Yes  No

(b) Blood vessels  Yes  No

(c) Visceral organs  Yes  No

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(x) Is the diagnosis of **Scleroderma** unequivocally supported by biopsy evidence?  Yes  No  
If "Yes", please advise:

Date of biopsy test done (ddmmyyy)	Detail of biopsy evidence to support the diagnosis

If "No", please indicate the clinical basis of the diagnosis of **Scleroderma**.

Please attach a copy of the relevant biopsy reports.

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(xi) Is the diagnosis of **Scleroderma** unequivocally supported by serological evidence?  Yes  No  
If "Yes", please advise:

Date of serological test done (ddmmyyy)	Type(s)/Name(s) of serological test	Detail of serological evidence to support the diagnosis

If "No", please indicate the clinical basis of the diagnosis of **Scleroderma**.

Please attach a copy of relevant the serological reports.

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2) Name and address of the doctor who **First** diagnosed the patient with the diagnosis:

3)	Please describe in detail the progression of the illness/condition since it was <b>First</b> diagnosed:																		
4)	Please describe the extent of the illness/condition when the patient was <b>Last</b> seen at your hospital/clinic:																		
5)	Is the heart involved in the diagnosis of <b>Scleroderma</b> ? If "Yes", please indicate the clinical basis of the heart involved in the diagnosis of <b>Scleroderma</b> .	<input type="checkbox"/> Yes	<input type="checkbox"/> No																
6)	Are the lungs involved in the diagnosis of <b>Scleroderma</b> ? If "Yes", please indicate clinical basis of the lungs involved in the diagnosis of <b>Scleroderma</b> .	<input type="checkbox"/> Yes	<input type="checkbox"/> No																
7)	Are the kidneys involved in the diagnosis of <b>Scleroderma</b> ? If "Yes", please indicate clinical basis of the kidneys involved in the diagnosis of <b>Scleroderma</b> .	<input type="checkbox"/> Yes	<input type="checkbox"/> No																
8)	Please indicate if the patient is suffering from any of the following: (i) Localised scleroderma (linear scleroderma or morphea) (iii) Eosinophilic fasciitis If "Yes" to any of the above, please indicate date of <b>First</b> diagnosis (ddmmyyy):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No														
		<table border="1" style="display: inline-table; border-collapse: collapse; width: 150px; height: 20px;"> <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> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>																	
9)	Please indicate whether the patient is suffering from CREST Syndrome?  If "Yes", please advise: (i) Is there skin with deposits of calcium (calcinosis)? (ii) Is there skin thickening of the fingers or toes (sclerodactyly)? (iii) is there esophagus involved? (iv) Is there telangiectasia (dilated capillaries)? (v) Is there Raynaud's Phenomenon causing artery spasms in the extremities?  Please state date of <b>First</b> diagnosis (ddmmyyy):  If "No" to i) to v), please indicate the clinical basis of the diagnosis with CREST Syndrome.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No										
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10) Please provide full details and results of all **investigations** (with dates) performed for the diagnosis.  
Also, please **attach** a copy of all relevant test report(s).

11) Please provide details of **treatment** prescribed, with dates (e.g. immunosuppressive therapy, anti-fibrotic agents, etc.).

12) 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>		

13) 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>		

14) 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 (dd/mm/yyyy)

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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 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 been rejected in favour of the 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 <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), if any.</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>				
<p>8) (i) Is the patient mentally incapacitated? <span style="float: right;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</span></p> <p>(ii) If the patient is mentally incapacitated, is he/she mentally capable of receiving or handling money? <span style="float: right;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</span></p>				
<p>9) Are you aware of any other doctor(s), in Singapore or overseas whom the patient consulted for <b>condition or any other related diseases</b>? <span style="float: right;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</span></p> <p>If "Yes", please advise:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border-bottom: 1px solid black;"><u>Name of doctor and Address of hospital/clinic</u></td> <td style="width: 33%; border-bottom: 1px solid black;"><u>Date of First &amp; Last consultation</u></td> <td style="width: 33%; border-bottom: 1px solid black;"><u>Reasons for consultation</u></td> </tr> </table>	<u>Name of doctor and Address of hospital/clinic</u>	<u>Date of First &amp; Last consultation</u>	<u>Reasons for consultation</u>	
<u>Name of doctor and Address of hospital/clinic</u>	<u>Date of First &amp; 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 (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 include the following:

- (i) Biopsy reports
- (ii) Blood test reports
- (iii) Computerised tomography scan (CT scan)
- (iv) Magnetic resonance imaging (MRI), other imaging studies
- (v) Serological test reports
- (vi) X-Ray
- (vii) Operation reports, surgical reports
- (viii) Referral letters (if any)
- (ix) 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)	