



**Critical Illness Claim - Doctor's Statement
Special Benefit – Autism of Specified Severity**

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. 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?

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) **Final** Diagnosis of the condition:

(vi) ICD-10 Code:

(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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2) Name and address of the doctor who **First** diagnosed the patient with the condition.

3) Please provide full details and results of all **investigation(s)** (with dates) performed for the diagnosis.
Also, please **attach** a copy of all the relevant test reports.

4) Name and address of doctor that the patient is seeing for management of his/her medical condition.

5) Has the diagnosis of Autism

(i) continued without interruption for a period of at least six (6) months after the diagnosis? Yes No
If "Yes", please advise:

a) Date of commencement (ddmmyyyy)

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(ii) supported by two (2) different assessments performed at least six (6) months apart? Yes No
If "Yes", please advise

Date of Tests (ddmmyyyy) Name of Tests

6) Has the patient underwent treatment such as but not limited to behavioural therapy, psychological interventions or special education at recognised institute? Yes No
If "Yes", please advise:

Date of Treatments (ddmmyyyy) Type of Treatments Name and Address of Medical Institutes

7) (i) Was the diagnosis of Autism confirmed according to the criteria of Diagnostic and Statistical Manual of Mental Disorders (DSM)-5 or any subsequent DSM update or alternative supersedes DSM? Yes No
If "Yes", please advise:

Date of Tests (ddmmyyyy) Name of Tests Results of Tests

(ii) Was the above Tests certified by the attending registered specialist in Paediatric Psychiatry or Paediatric Neurology? Yes No

If "Yes", please advise:

Name of doctor

Name and Address of hospital/clinic

(iii) Was the diagnosis of Autism classified as severity Level three (3) (requiring very substantial support assessed separately for each domain)? Yes No

If "No", please advise the severity Level: _____

8) Please provide details on the following:

Please tick	Symptoms presented	Date of Commencement (ddmmyyy)	Date of Last review (ddmmyyy)	Please elaborate with supporting evidence
	Symptoms must be present in the early developmental period.			
	Symptoms caused clinically significant impairment in social, occupational, or other important areas of current functioning.			
	Severe deficits in verbal and non-verbal social communication skills causing severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others.			
	Inflexibility of behaviour, extreme difficulty coping with change, or other restricted / repetitive behaviours markedly interferes with functioning in all spheres. Great distress / difficulty changing focus or action.			
	Others Please indicate:			

9) Was the patient admitted at the 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 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", 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?

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

4) Have active treatment and therapy been rejected in favour of the relief of symptoms? Yes No

If "Yes", please provide full details and explain the reason for this course of action.

5) 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? Yes No

(ii) Twelve (12) months? Yes 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.

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

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.

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 the 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>

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) Computerised tomography scan (CT scan)
- (ii) Electroconvulsive therapy reports
- (iii) X-Ray
- (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 (ddmmyyy)