



**Critical Illness Claim - Doctor's Statement
Special Benefit - Dengue Haemorrhagic Fever**

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

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| 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> | | | | | | | | |
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| 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> | | | | | | | | |
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| (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> | | | | | | | | |
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| (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> | | | | | | | | |
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| 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> | | | | | | | | |
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| (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> | | | | | | | | |
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| (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 give details of the patient's **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 give 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) **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) Name and address of doctor that the patient is seeing for management of his/her condition.

4) 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.

5) Is the diagnosis considered as

(i) Dengue Haemorrhagic Fever Stage 3, based on the World Health Organisation? Yes No

(ii) Dengue Haemorrhagic Fever Stage 4, based on the World Health Organisation? Yes No

(iii) Other Stages of Dengue Haemorrhagic Fever, based on the World Health Organisation? Yes No

Please provide the Stage: _____

If "Yes" to any of above, please provide the following (a) to (g).

a) Is the dengue infection confirmed by a serological testing? Yes No

If "Yes", please provide the result(s) of the serological test(s) which confirmed the diagnosis:

| <u>Type of test/assessment</u> | <u>Date of test/assessment</u> | <u>Results of test/assessment</u> |
|--------------------------------|--------------------------------|-----------------------------------|
| | | |

b) Is there history of continuous high fever for two (2) or more days? Yes No

If "Yes", please provide the following dates (dd/mm/yyyy):

From

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To

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c) Are there minor or major haemorrhagic manifestations? Yes No

If "Yes", please provide the result(s).

d) Is there thrombocytopenia (less than or equal to 100000 per mm³)? Yes No

If "Yes", please provide the result(s).

e) Is there haemoconcentration (haematocrit increased by 20% or more)? Yes No
 If "Yes", please provide the result(s).

f) Is there evidence of evidence of plasma leakage (i.e. pleural effusion, ascites or hypoproteinaemia, etc.)? Yes No
 If "Yes", please provide details of the plasma leakage:

Type of test/assessment Date of test/assessment Results of test/assessment

g) Is there evidence of Dengue Shock Syndrome (DSS)? Yes No

a) Is there evidence of hypotension (less than 80 mm Hg) or narrow pulse pressure (20 mm Hg or less)? Yes No

b) Is there evidence of tissue hypoperfusion such as cold, clammy skin, oliguria, or metabolic acidosis? Yes No

If "Yes", please provide details of the Dengue Shock Syndrome (DSS):
Type of test/assessment Date of test/assessment Results of test/assessment

Please provide the results of investigations done and attach copies of reports.

6) Was the patient admitted at the hospital for treatment of the diagnosis? Yes No
 If "Yes", please advise:

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| 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) | | |

7) Was the patient admitted to Intensive Care Unit (ICU) for treatment of the diagnosis? Yes No
 If "Yes", please advise:

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| 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) | | |

8) Is the patient's diagnosis directly or indirectly, wholly or partly caused by, arising from, 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) 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.

3) 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.

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

5) 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.

6) a) Is the patient mentally incapacitated? Yes No

b) If the patient is mentally incapacitated, is he/she mentally capable of receiving or handling money? Yes No

7) Are you aware of any other doctor(s), in Singapore or overseas, whom the patient consulted for the **condition or any possible 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> |
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8) 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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9) 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) Blood test reports
- (ii) Computerised tomography scan (CT scan)
- (iii) Magnetic resonance imaging (MRI), other imaging studies
- (iv) Serological test reports
- (v) X-Ray
- (vi) Operation reports, surgical reports
- (vii) Referral letters (if any)
- (viii) 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)