



Critical Illness Claim - Doctor's Statement
Stroke with Permanent Neurological Deficit / Brain Aneurysm Surgery /
Cerebral Shunt Insertion / Carotid Artery Surgery

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. cyst, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, anaemia, etc.)? If "Yes", please provide: <u>Details of symptoms</u> <u>Exact diagnosis</u> <u>Date diagnosed</u> <u>Treatment</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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 past and present smoking habits, including the duration of smoking habit(s), number of cigarettes smoked per day and source of this information. <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 alcohol consumption habits, including the amount of the alcohol consumption, frequency, and the source of this information. <u>Type of alcohol</u> <u>Quantity per Consumption</u> <u>Frequency (per week / month, etc)</u> <u>Source of information</u>	

C) Details of Illness											
1) Please provide details of the condition:											
(i) Date the patient First consulted 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> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
(ii) Details of symptom(s) presented at First 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:											
(vi) ICD-10 Code:											
(vii) Date of First 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> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
(viii) Date the patient First became aware of the illness/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>										

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

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

4) Please describe the initial episode:

(i) Nature of episode:

(ii) Date of initial episode (ddmmyyyy)

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(iii) Duration of acute symptoms:

5) Was there any permanent neurological deficit lasting for at least six (6) weeks after the initial episode of Stroke? Yes No

If "Yes", please provide details on the permanent neurological deficit with persisting clinical symptoms which means symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the lifetime of the patient:

Please tick	Neurological deficit	Date of Last review confirming the neurological deficit (ddmmyyyy)	Please specify the exact body parts involved	Is the neurological deficit permanent and expected to last throughout the lifetime?	Please elaborate with supporting evidence
	Numbness			YES / NO	
	Paralysis			YES / NO	
	Localised weakness			YES / NO	
	Dysarthria (difficulty with speech)			YES / NO	
	Aphasia (inability to speak)			YES / NO	
	Dysphagia (difficulty swallowing)			YES / NO	
	Visual Impairment			YES / NO	
	Difficulty in walking			YES / NO	
	Lack of coordination			YES / NO	

	Tremor			YES / NO	
	Seizures			YES / NO	
	Dementia			YES / NO	
	Delirium			YES / NO	
	Coma			YES / NO	
	Others, please specify:			YES / NO	

6) Has there been an infarction of brain tissue, cerebral and subarachnoid haemorrhage, intracerebral embolism and cerebral thrombosis? Yes No
If "Yes", please provide full details.

7) Are the investigations or findings consistent with the diagnosis of a new Stroke? Yes No
If "Yes", please provide details and attach a copy of all reports, CT Scan, MRI, laboratory test results, etc.

8) Please provide details of the surgery and/or other mode of treatment that had been performed, including type and date of treatment, and name and address of attending specialist.

9) Please confirm the following:

(i)	Is this a Transient Ischaemic Attack?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(ii)	Is this an attack of Vertebrobasilar ischaemia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(iii)	Was the brain damaged due to an accident or injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(iv)	Was the brain damaged due to an infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(v)	Was the brain damaged due to a vasculities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(vi)	Was the brain damaged due to an inflammatory disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(vii)	Was the condition due to vascular disease effecting the eye?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(viii)	Was the condition due to vascular disease effecting the optic nerve?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(ix)	Was the condition due to ischaemic disorder of the vestibular system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

10) Has the patient undergone any **Brain Aneurysm Surgery**? Yes No

If "No", please proceed to **Question 11**.

If "Yes", please advise:

(i) Was an arteriogram / cerebral angiogram carried out? Yes No

If "Yes", please advise:

(ii) Date of arteriogram performed (ddmmyyyy)

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Please attach a copy of the report.

(iii) Was surgery carried out to correct
a) intracranial aneurysm? Yes No

b) arterio-venous malformation of one (1) or more of the cerebral arteries? Yes No

(iv) Date of surgery (ddmmyyyy)

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(v) Nature of surgery

(vi) Was surgery done via endovascular? Yes No

If "No", please state the type of surgery performed.

(vii) Was surgery done via craniotomy? Yes No

If "No", please state the type of surgery performed.

(viii) Was surgery done via Gamma Knife radiosurgery? Yes No

If "No", please state the type of surgery performed.

(ix) Was the surgery performed certified to be absolutely necessary by a
neurosurgeon/neurologist? Yes No

Please attach a copy of the tomography (CT) scan, magnetic resonance imagin (MRI), magnetic resonance angiograph (MRA) or angiogram.

11) Has the patient undergone any **Cerebral Shunt Insertion**? Yes No

If "No", please proceed to **Question 12**.

If "Yes", please advise:

(i) How was this diagnosis established?

Please include a copy of diagnostic investigation report.

(ii) Is the patient's condition of hydrocephalus congenital in nature? Yes No

If "No", please indicate the cause of hydrocephalus.

(iii) Was there any intracranial pressure giving rise to neurological deficit as a result of hydrocephalus? Yes No

If "Yes", please indicate the neurological deficit(s).

(iv) Was there surgical implantation of a shunt from the ventricles of the brain? Yes No

If "Yes", please advise:

a) Date of shunt insertion (ddmmyyyy)

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(v) Was the surgical implantation of a shunt from the ventricles of the brain to relieve raised pressure in the cerebrospinal fluid? Yes No

(vi) Was the surgery performed considered medically necessary by the consultant neurosurgeon? Yes No

(vii) Is there other mode of treatment other than shunt insertion, which could have been used to treat the patient's hydrocephalus? Yes No

If "Yes", please state the nature of treatment and why this treatment was not used.

12) Did the patient suffer from **narrowing of the Carotid Artery**? Yes No
 If "No", please proceed to **Section D**.
 If "Yes", please advise:

(i) Was an arteriography carried out? Yes No
 If "Yes", please provide a copy of report.

(ii) Please state the percentage of narrowing of the carotid artery. %

(iii) Was Endarterectomy carried out to correct the carotid artery? Yes No
 If "Yes", please state the date of surgery (ddmmyyyy)

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 If "No", please state the type of treatment provided.

(iv) Was Endarterectomy of blood vessels other than the carotid artery done? Yes No

D) Other Information

1) Was the patient admitted to a 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)		

2) 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)		

3) Is the patient's diagnosis or surgery 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)

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).

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

5) Is there anything in the patient's **lifestyle** or **personal medical history** may have increased the risk of condition? Yes No

If "Yes", please advise:

Type of Lifestyle / Exact diagnosis

Date of diagnosis

Name of doctor & Address of hospital/clinic

6) Is there anything in the patient's **family history** which 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

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

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

8) 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.

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

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.

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

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 & 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 (ddmmyyy)

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If "No", please state date of discharge (ddmmyyy), 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) Magnetic resonance imaging (MRI), other imaging studies
- (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)