* S U P D O C *

Singlife

Critical Illness Claim - Doctor's Statement
Systemic Lupus Erythematosus with Lupus Nephritis / Mild Systemic Lupus Erythematosus

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)

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):

(ii) Date of **Last** consultation (ddmmyyyy):

(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? ❒ Yes ❒ No

If "Yes", since when? (ddmmyyyy):

If "No", please provide name and address of the patient's regular doctor:

3) Was the patient referred to you? ❒ Yes ❒ No

If "Yes", please advise:

(i) Date referred (ddmmyyyy):

(ii) Reason for referral:

(iii) Name and address of referring doctor:

If "No", please indicate howthe patient came to consult at your hospital/clinic? (e.g. A&E.)

4) Have you referred the patient to any other doctor? ❒ Yes ❒ No

(i) Date referred (ddmmyyyy):

(ii) Reason for referral:

(iii) Name and address of doctor referred to:

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5) Does the patient have or ever have had any significant health conditions, medical history, or any illness (e.g. tumour, diabetes, hypertension, abnormal urinalysis 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 (ddmmyyyy): | | | | | | | | |

(ii) Details of symptom(s) presented at **First** consultation:

(iii) Date of onset of these symptoms (ddmmyyyy): | | | | | | | | |

(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): | | | | | | | | |

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

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2) Was the diagnosis of **Systemic Lupus Erythematosus** confirmed by specialist in Rheumatology and Immunology? ❒ Yes ❒ No

If "Yes", please provide the Name and address of the specialist who **First** diagnosed the patient of **Systemic Lupus Erythematosus** condition.

3) Are the following internal organs affected due to the diagnosis of **Systemic Lupus Erythematosus**?

(i) Kidneys? ❒ Yes ❒ No

(ii) Brain? ❒ Yes ❒ No

(iii) Heart or pericardium? ❒ Yes ❒ No

(iv) Lungs or pleura? ❒ Yes ❒ No

(v) Joints as the presence of polyarticular inflammatory arthritis? ❒ Yes ❒ No

(vi) Skin? ❒ Yes ❒ No

If "Yes" to any of the above, please describe the nature and extent of the impairment, with date(s) (ddmmyyyy):

4) Was the patient diagnosed of discoid lupus and those forms with haematological involvement? ❒ Yes ❒ No

If "Yes", please provide details:

5) If the kidneys were affected, was renal biopsy performed? ❒ Yes ❒ No

If "Yes", please advise on the following:

(i) Elaborate on the biopsy results:

(ii) Date of the renal biopsy done (ddmmyyyy): | | | | | | | | |

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6) Is there evidence of Lupus Nephritis? ❒ Yes ❒ No

If "Yes", please advise on the following:

(i) Describe the symptoms:

(ii) Was renal biopsy performed? ❒ Yes ❒ No

If "Yes", please advise on the following:

a) Elaborate on the biopsy results:

b) Date of the renal biopsy done (ddmmyyyy): | | | | | | | | |

(iii) Based on the renal biopsy performed, please indicate the appropriate staging of the patient's lupus nephritis in accordance with the World Health Organization (WHO) classification:

a) **Class I** Minimal Change Lupus Glomerulonephritis ❒ Yes ❒ No

b) **Class II** Mesangial Lupus Glomerulonephritis ❒ Yes ❒ No

c) **Class III** Focal Segmental Proliferative Lupus Glomerulonephritis ❒ Yes ❒ No

d) **Class IV** Diffuse Proliferative Lupus Glomerulonephritis ❒ Yes ❒ No

e) **Class V** Membranous Lupus Glomerulonephritis ❒ Yes ❒ No

(iv) Based on the renal biopsy performed, please indicate the appropriate staging of the patient's lupus nephritis in accordance with the Renal Pathology Society / International Society of Nephrology (RPS/ISN) classification:

a) **Class I** Minimal mesangial lupus nephritis ❒ Yes ❒ No

b) **Class II** Mesangial proliferative lupus nephritis ❒ Yes ❒ No

c) **Class III** Focal lupus nephritis (active and chronic; proliferative and sclerosing) ❒ Yes ❒ No

d) **Class IV** Diffuse lupus nephritis (active and chronic; proliferative and sclerosing; segmental and global) ❒ Yes ❒ No

e) **Class V** Membranous lupus nephritis ❒ Yes ❒ No

f) **Class VI** Advanced sclerosis lupus nephritis ❒ Yes ❒ No

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7) Is the patient currently on systematic lupus immunosuppressive therapy due to involvement of multiple organs? ❒ Yes ❒ No

If "Yes", please advise on the following:

(i) Date of systematic lupus immunosuppressive therapy **First** started (ddmmyyyy):

(ii) Has the systematic lupus immunosuppressive therapy lasted for a period of at least 6 months? ❒ Yes ❒ No

If "No", please provide the reason:

8) 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 including antibody tests i.e. ANA panel, Chest X-Ray, renal biopsy, urinalysis, laboratory tests such as RFT, CBC, rheumatoid factor etc.

9) What treatment has been administered?

10) Please provide details of **ongoing** treatment:

11) 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)		

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12) 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)		

D) Other Information

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

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

3) 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 give details:

Type of Lifestyle / Exact diagnosis	Date of diagnosis	Name of doctor & address of hospital/clinic

4) Has any of 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

5) 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.

6) 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.

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

8) 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.

9) (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

10) 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:

Name of doctor and Address of hospital/clinic	Date of **First** & **Last** consultation	Reasons for consultation

11) Is the patient still on follow-up at your hospital/clinic? ❒ Yes ❒ No

If "Yes", please advise date of next appointment (ddmmyyyy): | | | | | | | | |

If "No", please state date of discharge (ddmmyyyy), if any: | | | | | | | | |

12) Please provide us with any other additional information that may assist the Company in assessing this claim:

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Please enclose copies of 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) Renal biopsy reports
(v) Renal function 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 & Offical Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	

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