



**Critical Illness Claim - Doctor's Statement  
Special Benefit - Urinary Incontinence requiring Surgical Repair**

**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"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </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"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>								
(ii) Date of <b>Last</b> consultation (ddmmyyyy)	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </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"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </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"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </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?  Yes  No

(i) Date referred (ddmmyyyy) 

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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:

<u>Details of symptoms</u>	<u>Exact diagnosis</u>	<u>Date diagnosed</u>	<u>Treatment</u>
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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 habits, 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>
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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>
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**C) Details of Illness**

1) Please provide details of the condition:

(i) Date the patient **First** consulted you for the condition (ddmmyyyy): 

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

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

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(iv)	What is/are the underlying cause(s) of the symptoms?									
(v)	<b>Final</b> Diagnosis of the condition:									
(vi)	ICD-10 Code:									
(vii)	Date of <b>First</b> diagnosis (ddmmyyyy)	<table border="1" style="display: inline-table; border-collapse: collapse;"> <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> </tr> </table>								
(viii)	Date the patient <b>First</b> became aware of the illness/condition (ddmmyyyy)	<table border="1" style="display: inline-table; border-collapse: collapse;"> <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> </tr> </table>								
2) Name and address of the Hepatologist who <b>First</b> diagnosed the patient with the condition.										
3) Please provide full details and results of all <b>investigation(s)</b> (with dates) performed for the diagnosis. Also, please <b>attach</b> a copy of all the relevant test reports.										
4) Did the diagnosis result in urinary incontinence? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> If "Yes", please provide details:  If "No", please provide details:										
5) Has the patient undergone surgery to repair the urinary incontinence? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> If "yes", please provide details.										
(i)	Date of Surgery (ddmmyyyy)	<table border="1" style="display: inline-table; border-collapse: collapse;"> <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> </tr> </table>								
(ii)	Type of Surgical Repair performed.									
(iii)	Has the patient									
a)	placed under management of a Registered Medical Practitioner for at least six (6) months? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", please provide details.									
	Date of Commencement of Management (ddmmyyyy)	<table border="1" style="display: inline-table; border-collapse: collapse;"> <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> </tr> </table>								
b)	required continuous incontinence medical treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(iv)	Is the surgery medically necessary for the sole purpose of correcting the incontinence?	<input type="checkbox"/> Yes <input type="checkbox"/> No								

6) 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>		

7) 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>		

**D) Other Information**

1) 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 (ddmmyyy):

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

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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).

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 advise:

Type of Lifestyle / Exact diagnosis

Date of diagnosis

Name of doctor & address of hospital/clinic

4) 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

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.

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 state date of next appointment (ddmmyyyy)

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

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12) 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) Ultrasound & radiology reports
- (iv) X-Ray
- (v) Operation reports, surgical reports
- (vi) Referral letters (if any)
- (vii) 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)