* S U P D O C *

Singlife

Critical Illness Claim – Doctor's Statement
Motor Neurone Disease

SECTION 2 – 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 state over what period does the Hospital/Clinic's record extend?

(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 Reasons 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 provide:

(i) Date referred (ddmmyyyy)

(ii) Reason the patient was referred:

(iii) Name and address of doctor recommending the referral:

If "No", how did the patient come 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, hyperlipidaemia, hepatitis, etc.)? ❒ Yes ❒ No
If "Yes", please provide:

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 habits in relation to past and present **smoking**, 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 habits in relation to **alcohol consumption**, 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 **Motor Neurone Disease***:*

(i) Date the patient First consulted you for this condition (ddmmyyyy) | | | | | | | | |

(ii) Details of symptom(s) presented at first consultation, and date these symptoms First started.

(iii) What is the underlying cause(s) of the symptoms?

(iv) Exact Diagnosis of the condition (including type of motor neurone disease, e.g. Amyotrophic lateral sclerosis, progressive bulbar palsy, etc.):

ICD-10 Code (if applicable):

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(v) Date of **First** diagnosis (ddmmyyyy)

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

2) Name and address of the Neurologist who **First** diagnosed the patient of Motor Neurone Disease.

3) Please provide the details of all investigations performed to establish the diagnosis (e.g. electromyogram, nerve conduction studies, brain and spinal cord MRI, etc.)?

Name of Investigation	Date of Investigation	Results of Investigation

Please attach a copy of the above investigation reports.

4) Please describe in full details (with dates) the extent of neurological deficit.

5) Are the neurological deficit (mentioned in Question 4):

(i) Progressive? ❒ Yes ❒ No

(ii) Permanent? ❒ Yes ❒ No

(a) If "Yes", please elaborate with supporting evidence.

(b) If "No", please state date of recovery *or* date for which the patient is likely to recover from these neurological deficits: (ddmmyyyy)

6) Please provide details of **current treatment.**

7) 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)

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D) Other Information

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

2) Has the patient previously suffered from the abovementioned condition(s) and/or any related illness, however minor in nature, concerning neurological symptoms or complaints? ❒ Yes ❒ No

If "Yes", please give details:

Name of doctor and Address of hospital/clinic	Date of first & last consulation	Diagnosis

3) Has the patient ever been hospitalised for **Motor Neurone Disease** and/or its related symptoms or complications? If "Yes", please advise: ❒ Yes ❒ No

Date of hospitalisation	Reasons for hospitalisation	Treatment received (including operation, if any)	Name of doctor/surgeon & Address of hospital

4) Is there anything in the patient's **personal medical history** or **family history** which would have increased the risk of the Motor Neurone Disease or its related illness? ❒ Yes ❒ No

If "Yes", please give details:

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

5) Please describe the nature and severity of the patient's **physical** and **mental** disability and limitation, if any.

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6) Has active treatment and therapy now been rejected in favour of relief of symptoms? ❒ Yes ❒ No
If "Yes", please provide full details why this view / course of action is taken.

7) Can you confirm that the advent of death is highly probable within:
(i) six (6) months? ❒ Yes ❒ No
(ii) twelve (12) months? ❒ Yes ❒ No

If "Yes", please describe and provide relevant medical reports that support this view.

8) Please provide us with any other additioanl information that will enable the Company to assess this claim.

9) Please enclose a copy of all reports including specialist or hospital reports, lelectromyogram, nerve conduction studies, MRI – brain and/or spincal cord, laboratory evidence, surgical report, etc. that are available.

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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