* S U P D O C *

Singlife

Critical Illness Claim - Doctor's Statement
Paralysis (Loss of Use of Limbs)

SECTION 2 – DOCTOR'S STATEMENT (to be completed by the attending doctor at claimant's expense)

A) Patient's Particulars

Name of Patient	Gender	Occupation

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, hepatitis, diabetes, hypertension, hyperlipidaemia, overweight, etc.) If "Yes", please provide: ❒ Yes ❒ No

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 Disability / Illness

1) Please provide details of **Paralysis** / **Loss of use of limbs** condition:

(i) Date of First consultation for this current condition (ddmmyyyy)

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

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

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(iv) Exact Diagnosis of the condition:

ICD-10 Code (if applicable):

(v) Date of first diagnosis (ddmmyyyy)

(vi) Date the patient first became aware of the illness/condition (ddmmyyyy)

2) Name and address of the Neurologist who **First** diagnosed the patient with this condition.

3) Please provide full details and results of all **investigations** (with dates) undertaken for the diagnosis and **attach** a copy of all relevant test reports which confirmed the diagnosis.

4) Was the paralysis or loss of use of limbs condition a result of an **Accident**? ❒ Yes ❒ No

If "No", please proceed to Question 5.

If "Yes", please advise:

(i) Date of Accident (ddmmyyyy)

(ii) Time of Accident (a.m. / p.m.)

(ii) Place of Accident:

(iv) Describe in details how the accident happened.

(v) Describe the extent and severity of the bodily injuries/disability sustained, including exact site(s) of the body.

(vi) Was the accident reported to the police? ❒ Yes ❒ No

If "No", why not?

If "Yes", please provide the following information and **attach** a copy of the police report.

Police Division Name of Police Officer-in-charge

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(vii) Was the patient under the influence of alcohol and/or drugs at the time of accident? ❒ Yes ❒ No

If "Yes", please elaborate (e.g. result of blood alcohol concentration, alcohol breath test; name of drugs, quantity consumed, etc.)

(viii) Did the patient have any medical condition(s) that had contributed to the accident (e.g. fits)? ❒ Yes ❒ No

If "Yes", please provide full details.

5) (i) Please state the limb(s) involved and the extent of loss of use:

Specific Limb	**Extent of loss of use (if applicable)**	**Is the loss of use total and irreversible? (circle as appropriate)**
Left Upper limb		Yes / No
Left Lower limb		Yes / No
Right Upper limb		Yes / No
Right Lower limb		Yes / No

(ii) If the loss of use of the involved limb(s) is total and irreversible, please advise:

The basis of the assessment: First date of such continuous loss of use

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6) Please state your assessment of the patient's **limb power**:

Date of Assessment (ddmmyyyy)		**Limb Power**		**Limb Power**
	Left upper limb		Right upper limb	
	Left lower limb		Right lower limb	

7) Please state your assessment of the patient's **power grip** and **precision grip**:

Date of Assessment (ddmmyyyy)		**Power Grip**	**Precision Grip**
	Left upper limb		
	Right upper limb		

8) Please provide full details (with dates) of all the investigation test reports/results and assessment reports as the basis of your evaluation to Question 5 to 7.

9) Did the paralysis result from a self-inflicted act? ❒ Yes ❒ No

If "Yes", please provide full details.

10) Please provide in details the **treatment** prescribed with **dates**, including type of operation performed, rehabilitation programs (e.g. Physiotherapy – number of cycles, commencement and termination date), medication, any surgery contemplated, etc.

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11) What are the name of the doctor(s) and hospital/clinic where the patient received and/or is receiving the abovementioned treatment?

12) What was the patient's response to the treatment?

13) Please tick in the relevant box below whether the patient's condition is likely to:

(i) Improve ❒ *or* Deteriorate ❒ *or* Remain static ❒

(ii) If "Improve", please state the extent of improvement expected and the estimated date of recovery.

(iii) If "Deteriorate" or "Remain static", please elaborate with reasons how you arrive at the opinion.

D) Other Information

1) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for **Paralysis or the loss of use of limbs, or any possible related illness**, especially any consultations 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	Reasons for consultation

2) Is there anything in the patient's **personal medical history** or **family history** which would have increased the risk of the Paralysis or the loss of use of limbs and/or its related illness? ❒ Yes ❒ No
If "Yes", please give details:

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

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3) Please provide us with any other additional information that will enable the Company to assess this claim.
4) Please enclose a copy of all reports including specialist/physiotherapist/hospital/police reports, x-rays, CT scans, laboratory test results, inpatient discharge summary 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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