* S U P D O C *

Critical Illness Claim - Doctor's Statement
Necrotising Fasciitis / Necrotising Fasciitis requiring hospitalization / Necrotising Fasciitis requiring 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)

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 provide:

(i) Date referred (ddmmyyyy):

(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):

(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. brain herniation, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, 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 past and present **smoking** habits, including the duration of smoking habit(s), 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 **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 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): | | | | | | | | |

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

2) Is the Necrotizing Fasciitis due to a bacterial infection? ❒ Yes ❒ No
If "Yes", please provide details:

3) Is there widespread destruction of muscle and other soft tissues that resulted in a total and permanent loss of function of the affected body part? ❒ Yes ❒ No

If "Yes", please advise:

(i) Details of the body part which was affected by widespread destruction of muscle and other soft tissues:

(ii) Details of the total and permanent loss of function of the affected body part mentioned under (i):

6) Name and address of the **surgeon** who **First** diagnosed the patient with the condition:

7) Please provide full details and results of all **investigation** (with dates) performed for the diagnosis.
Also, please **attach** a copy of all the relevant test reports including **the blood culture etc**

8) Please provide details of current **treatment**, including name and dosage of medication, operation contemplated (if any).

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9) Was the patient admitted to 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)		

10) 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)		

11) Please confirm the following:

(i) Is the diagnosis considered Fournier's gangrene? ❒ Yes ❒ No

(ii) Is the diagnosis considered Gas gangrene? ❒ Yes ❒ No

(iii) Is the diagnosis considered Gangrene caused by diabetes? ❒ Yes ❒ No

(iv) Is the diagnosis considered Gangrene caused by neuropathy? ❒ Yes ❒ No

(v) Is the diagnosis considered Gangrene caused by vascular diseases? ❒ Yes ❒ No

If "Yes" to any of the above, please provide details including the date of diagnosis, name and address of the **surgeon** who made the diagnosis, and the source of information.

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12) 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).

D) Other Information

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

2) 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

3) 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

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4) 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.

5) 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 relevant details forming the basis of your evaluation:

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

7) 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.

8) (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

9) 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

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

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

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

11) 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) Blood test reports
(ii) Computerised tomography scan (CT scan)
(iii) Magnetic resonance imaging (MRI), other imaging studies
(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 & Offical Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	

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