Critical Illness Claim - Doctor's Statement
Stroke / Brain Aneurysm Surgery or Cerebral Shunt Insertion / Carotid Artery Surgery

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. cyst, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, anaemia, 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 **Stroke**:

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

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

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

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

(v) Exact Diagnosis of the condition:

ICD-10 Code (if applicable):

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

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

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2) Please provide dates and details of investigation performed for the diagnosis and attach a copy of all relevant test reports which confirmed the diagnosis.

3) Name and address of the doctor who **First** diagnosed the patient with this condition.

4) Please describe the initial episode:

(i) Nature of episode:

(ii) Date of initial episode (ddmmyyyy)

(iii) Duration of acute symptoms:

5) Was there any permanent neurological deficit lasting for at least six (6) weeks after the initial episode of Stroke? ❒ Yes ❒ No

If "Yes", please provide details on the permanent neurological deficit with persisting clinical symptoms which means symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the lifetime of the patient:

Please tick	**Neurological deficit**	**Date of Last review** confirming the neurological deficit (ddmmyyyy)	**Please specify the exact body parts involved**	**Is the neurological deficit permanent and expected to last throughout the lifetime?**	**Please elaborate with supporting evidence**
	Numbness			YES / NO	
	Paralysis			YES / NO	
	Localised weakness			YES / NO	
	Dysarthria (difficulty with speech)			YES / NO	
	Aphasia (inability to speak)			YES / NO	
	Dysphagia (difficulty swallowing)			YES / NO	
	Visual Impairment			YES / NO	
	Difficulty in walking			YES / NO	
	Lack of coordination			YES / NO	
	Tremor			YES / NO	

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	Seizures			YES / NO	
	Dementia			YES / NO	
	Delirium			YES / NO	
	Coma			YES / NO	
	Others, please specify:			YES / NO	

6)	Has there been an infarction of brain tissue, haemorrhage, embolism and thrombosis from an extracranial souce? If "Yes", please provide full details.	❒ Yes ❒ No
7)	Are the investigations or findings consistent with the diagnosis of a new Stroke? If "Yes", please provide details and attach a copy of all reports, CT Scan, MRI, laboratory test results, etc.	❒ Yes ❒ No
8)	Please provide details of the surgery and/or other mode of treatment that had been performed, including type and date of treatment, and name and address of attending specialist.	
9)	Please confirm the following:	
	(i) Is this a Transient Ischaemic Attack?	❒ Yes ❒ No
	(ii) Is this an attack of Vertebrobasilar Ischaemia?	❒ Yes ❒ No
	(iii) Was the brain damaged due to an accident or injury?	❒ Yes ❒ No
	(iv) Was the brain damaged due to an infection?	❒ Yes ❒ No
	(v) Was the brain damaged due to a vasculities?	❒ Yes ❒ No
	(vi) Was the brain damaged due to an inflammatory disease?	❒ Yes ❒ No
	(vii) Was this condition due to vascular disease effecting the eye?	❒ Yes ❒ No
	(viii) Was this condition due to vascular disease effecting the optic nerve?	❒ Yes ❒ No
	(ix) Was this condition due to ischaemic disorder of the vestibular system?	❒ Yes ❒ No

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10) Has the patient undergone any **Brain Aneurysm Surgery**? ❒ Yes ❒ No

If "No", please proceeds to **Question 11**.

If "Yes", please proceeds as follow:

(i) Was an arteriogram / cerebral angiogram carried out? If "Yes", please advise: ❒ Yes ❒ No

(ii) Date of arteriogram performed (ddmmyyyy)

Please attach a copy of the report.

(iii) Was surgery carried out to correct intracranial aneurysm or arterio-venous malformation? ❒ Yes ❒ No

If "Yes", please advise:

(iv) Date of surgery (ddmmyyy)

(v) Nature of surgery

(vi) Was surgery done via craniotomy? ❒ Yes ❒ No

If "No", please state the type of surgery performed.

(vii) Please attach a copy of the tomography (CT) scan, magnetic resonance imagin (MRI), magnetic resonance angiograph (MRA) or angiogram.

11) Has the patient undergone any **Cerebral Shunt Insertion**? ❒ Yes ❒ No

If "No", please proceeds to **Question 12**.

If "Yes", please advise:

(i) How was this diagnosis established? Please include a copy of diagnostic investigation report.

(ii) Is the patient's condition of hydrocephalus congenital in nature? ❒ Yes ❒ No

If "No", please indicate the cause of hydrocephalus.

(iii) Was there any intracranial pressure giving rise to neurological deficit as a result of hydrocephalus? If "Yes", please indicate the neurological deficit(s). ❒ Yes ❒ No

(iv) Was there surgical implantation of a shunt from the ventricles of the brain? ❒ Yes ❒ No

If "Yes", please state:

(v) Date of shun insertion (ddmmyyyy)

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(vi) Was the surgery performed considered medically necessary by the consultant neurosurgeon? ❒ Yes ❒ No

(vii) Is there other mode of treatment other than shunt insertion, which could have been used to treat the patient’s hydrocephalus? If “Yes”, please state the nature of treatment and why this treatment was not used. ❒ Yes ❒ No

12) Did the patient suffer from **narrowing of the Carotid Artery**? ❒ Yes ❒ No
If “No”, please proceeds to **Section D**.
If “Yes”, please advise:

(i) Was an arteriography carried out? If “Yes”, please provide a copy of report. ❒ Yes ❒ No

(ii) Please state the percentage of narrowing of the carotid artery. [ ] %

(iii) Was Endarterectomy carried out to correct the carotid artery? ❒ Yes ❒ No

If “Yes”, please state the date of surgery (ddmmyyyy)

If “No”, please state the type of treatment provided.

D) Other Information

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

2) Is the patient’s diagnosis or surgery directly or indirectly, wholly or partly caused by or arising from or contributed to by:

i) Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) infection? ❒ Yes ❒ No

If “Yes”, please state:

Date of Diagnosis of AIDS/HIV (ddmmyyyy):								
Date the patient **First** became aware of the condition (ddmmyyyy):								

ii) wilful misuse of drugs? ❒ Yes ❒ No

iii) wilful misuse of alcohol? ❒ Yes ❒ No

iv) congenital anomaly or defect? ❒ Yes ❒ No

If “Yes” for any of the above, please provide the details including diagnosis date, name of doctor and clinic who **First** diagnosed the patient with HIV or AIDS, wilful misuse of drugs, wilful misuse of alcohol or congenital anomaly or defect. Please provide copy of test result.

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3) Is there anything in the patient's **personal medical history** which would have increased the risk of Stroke, intracranial aneurysm, arterio-venous malformation, hydrocephalus or narrowing of carotid artery or any related illness (e.g. hypertension, transient ischaemic attack, angina, other cardiovascular disease, congenital anomaly or defect, etc)? If "Yes", please give etails: ❒ Yes ❒ No

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

4) Is there anything in the patient's **family history** which would have increased the risk of Stroke? If "Yes", please give details: ❒ Yes ❒ No

Relationship with patient	Nature of condition	Age of onset	Source of information

5) Based on the **Last** consultation, 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 provide details on the basis of your evaluation.

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

7) a) Is the patient mentally incapacitated? ❒ Yes ❒ No

b) If the patient is mentally incapacitated, is he/she mentally capable of receiving or handling money? ❒ Yes ❒ No

8) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for Stroke or any other related diseases? If "Yes", please give details: ❒ Yes ❒ No

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

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

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

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

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10) Please provide us with any other additional information that will enable us to assess this claim.
11) Please enclose a copy of all specialist or hospital reports, including magnetic resonance imaging, computerised tomography, or any reliable imagining technques, laboratory test results, 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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