



Living Benefit Claim - Doctor's Statement
Pregnancy Complications Benefit – Amniotic Fluid Embolism

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?
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?
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?
(i) Date referred (ddmmyyyy)
(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, diabetes, hypertension, hyperlipidaemia, anaemia etc.)? If "Yes", please provide: <u>Details of symptoms</u> <u>Exact diagnosis</u> <u>Date diagnosed</u> <u>Treatment</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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 <b>smoking</b> , 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>	
9) Please give details of the patient's habits in relation to <b>alcohol consumption</b> , 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>	

<b>C) Details of Illness</b>											
1) Please provide details of <b>Amniotic Fluid Embolism</b> condition.											
(i) Date the patient First consulted you for this condition (ddmmyyy)	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> </tr> </table>										
(ii) Details of symptom(s) presented at first consultation, and date these symptoms <b>first</b> started.											
(iii) Exact Diagnosis of the condition:  ICD-10 Code (if applicable):											
(iv) Date of <b>First</b> diagnosis (ddmmyyy)	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> </tr> </table>										
(v) Date the patient <b>First</b> became aware of this condition (ddmmyyy)	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> </tr> </table>										

2) Please advise if the following were present?

(a) Acute respiratory distress and shock?  Yes  No

(b) Respiratory Distress?  Yes  No

(c) Cardiovascular Collapse?  Yes  No

(d) Disseminated intravascular coagulation?  Yes  No

(e) Coma?  Yes  No

(f) Pulmonary Embolism as evident on lung scans?  Yes  No

Please provide copy of the investigation results to support the diagnosis.

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3) What is the underlying cause(s) of the amniotic fluid embolism?

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4) Was this pregnancy conceived through any of the following fertility treatments:

(a) Vitro Fertilization (**IVF**)  Yes  No

(b) Intra-Cytoplasmic Sperm (**ICSI**)  Yes  No

(c) Intrauterine Insemination (**IUI**)  Yes  No

(d) Intracervical Insemination (**ICI**)  Yes  No

(e) If none of the above, please specify the fertility treatment that the patient has received:

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5) Was the patient carrying 5 or more babies in this pregnancy?  Yes  No  
 If "No", please state the **number** of babies that the patient has carried in this single pregnancy.

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6) Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?  Yes  No  
 If "Yes", please provide the date of HIV/AIDS diagnosis (dd/mm/yyyy)

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7) Is the diagnosis related to self-inflicted injury, suicide or attempted suicide?  Yes  No

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8) Is the diagnosis related to any deliberate misuse of any drugs or alcohol?  Yes  No

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9) Is the diagnosis related to the use of unprescribed drugs where such drugs are required by the law to be prescribed by a registered medical doctor?  Yes  No

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10) Please enclose a copy of all reports including specialist or hospital reports, laboratory evidence, surgical report, etc.

<b>D) Declaration</b>	
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)	