* S U P D O C *

Singlife

Living Benefit Claim - Doctor's Statement
Pregnancy Complications Benefit – Uterine Rupture

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, 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 **Uterine Rupture** condition.

(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) Exact Diagnosis of the condition:

ICD-10 Code (if applicable):

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

(v) Date the patient **First** became aware of this condition (ddmmyyyy)

2) Was there rupture of uterus during pregnancy or childbirth? ❒ Yes ❒ No

If "Yes", did the rupture result in foetal death or hysterectomy? ❒ Yes ❒ No

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3) Was the patient underwent uterine repair as a result of uterine rupture? If "Yes" please provide a copy of the operation report.	❒ Yes ❒ No
4) Was hysterectomy performed as a result of the uterine rupture? If "Yes", please provide a copy of the operation report.	❒ Yes ❒ No
5) Was the disruption of the uterine wall also involves the overlying visceral peritoneum (uterine serosa)?	❒ Yes ❒ No
6) Was the rupture of uterus associated with the following, needing prompt caesarean delivery: (a) Significant uterine bleeding? (b) Foetal distress? (c) Protrusion or expulsion of the foetus and/or placenta into the abdominal cavity?	❒ Yes ❒ No ❒ Yes ❒ No ❒ Yes ❒ No
7) Was this pregnancy conceived through any of the following fertility treatments: (a) Vitro Fertilization (**IVF**) (b) Intra-Cytoplasmic Sperm (**ICSI**) (c) Intrauterine Insemination (**IUI**) (d) Intracervical Insemination (**ICI**) (e) If none of the above, please specify the fertility treatment that the patient has received:	❒ Yes ❒ No ❒ Yes ❒ No ❒ Yes ❒ No ❒ Yes ❒ No
6) Was the patient carrying 5 or more babies in this pregnancy? If "No", please state the **number** of babies that the patient has carried in this single pregnancy.	❒ Yes ❒ No
7) Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? If "Yes", please provide the date of HIV/AIDS diagnosis (dd/mm/yyyy)	❒ Yes ❒ No ☐☐☐☐☐☐☐☐
8) Is the diagnosis related to self-inflicted injury, suicide or attempted suicide?	❒ Yes ❒ No
9) Is the diagnosis related to any deliberate misuse of any drugs or alcohol?	❒ Yes ❒ No
10) 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
11) Please enclose a copy of all reports including specialist or hospital reports, laboratory evidence, surgical report, etc.	

D) 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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