AVIVA LTD

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DREAD DISEASE CLAIM – PHYSICIAN'S STATEMENT

Please complete all the sections in this report to the best of your knowledge. Any medical report fee will be borne by the claimant. In order for a claim under this Policy condition to be considered, either of the following definitions must be satisfied: -

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STROKE (CEREBROVASCULAR ACCIDENT)
Definition A
A cerebrovascular accident or incident producing permanent neurological sequelae lasting more than 24 hours, caused by haemorrhage, infarction of brain tissue or an embolus. Evidence of permanent neurological deficit must be produced. The permanent nature of a neurological defect has to be confirmed by a neurologist.

Specifically excluded are Transient Ischaemic Attacks and attacks of vertebrobasilar ischaemia.

Definition B
A cerebrovascular incident including infarction of brain tissue, cerebral and subarachnoid haemorrhage, cerebral embolism and cerebral thrombosis. The diagnosis must be supported by all of the following conditions:

(a) Evidence of permanent neurological damage confirmed by a neurologist at least 6 weeks after the event; and
(b) Findings on Magnetic Resonance Imaging, Computerised Tomography, or other reliable imaging techniques consistent with the diagnosis of a new sroke.

The following are excluded:

(i) Transient Ischaemic Attack;
(ii) Brain damage due to an accident or injury, infection, vasculitis, and inflammatory disease;
(iii) Vascular disease affecting the eye or optic nerve; and
(iv) Ischaemic disorders of the vestibular system.

Name of Patient : ____________________ Sex: M / F Age: ______________

NRIC/Passport No.: ____________________ Date of Birth : ____________________

Company : ____________________ Occupation : ____________________

PART A – PATIENT HISTORY

1) Please state over what period do your records extend:

a) Date of first consultation:

b) Date of last consultation:

c) Number of consultations during the above period:

d) What were the reasons of consultations (with dates)?

2) Are you the patient's usual doctor? ***YES / NO***
   (a) If "Yes", since what date?

   (b) If "No", please advise the name of the regular attending doctor and address of clinic / hospital.

3) Was the patient referred to you? ***YES / NO***
   (a) If "Yes", please advise (i) date referred, (ii) reason the patient was referred, (iii) name of doctor recommending the referral, and (iv) name and address of clinic / hospital.

   (b) If "No", how did he / she come to consult at your clinic or hospital (e.g. A&E)?

4) Have you referred the patient to any other doctor(s)? ***YES / NO*** If "Yes", please state (a) date referred, (b) reasons for referral, (c) name of doctor referred to, (d) and address of clinic/hospital.

5) Besides Stroke, does the patient have or ever have had any significant health conditions, medical history or any illness (e.g. diabetes mellitus, hypertension, hyperlipidaemia, angina, transient ischaemic attack, or any other vascular disease, etc)? ***YES / NO*** If "Yes", please advise:

   a) Details of Symptoms | Exact Diagnosis | Date of Diagnosis | Treatment

   b) Name of the Doctor(s) (and Clinic Address) whom the patient consulted for the condition(s) stated in (a) above

   c) What is your source of the above information?

6) Are you aware of any members of the patient's family having suffered from any cardiovascular, renal disease, hypertension, diabetes mellitus, neurological or musculoskeletal disorder? ***<u>YES / NO</u>*** If "Yes", please advise which family members, nature of illness and date of diagnosis.

7) 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.

8) Please give details of the patients' habits in relation to **alcohol consumption**, including the amount of alcohol consumption per day and the source of this information.

PART B - CONSULTATION FOR PRESENT ILLNESS/INJURY (IES)

1) Are you aware that the patient suffered from **Stroke**? ***YES / NO***

2) a) Date the patient FIRST noticed symptoms of Stroke:

   b) What symptoms did the patient notice then?

   c) Date the patient FIRST consulted a doctor for the symptoms:

3) a) Date you first attended to the patient for Stroke and / or symptoms related to it:

   b) Details of the symptoms presented when the patient first consulted you:

   c) Duration of symptoms:
      (i) According to the patient:

      (ii) In your opinion:

   d) Underlying cause(s) of the symptoms:

   e) Exact diagnosis of the condition:

4) Date Stroke condition was FIRST diagnosed:

5) Name of the doctor and address of hospital / clinic who made the FIRST diagnosis of the condition.

6) Was the patient informed of the above diagnosis? ***YES / NO***
   a) If “Yes”, date the patient was first informed of the above diagnosis?

   b) If “No”, why not?

7) Are the investigations or findings consistent with the diagnosis of new Stroke? ***YES / NO*** If “Yes”, please elaborate.

8) How long has the neurological damage lasted since the initial episode? ______________ weeks.

9) a) Please describe in detail the neurological damage.

   b) Is the damage likely to be permanent? ***YES / NO*** Please elaborate with reason(s).

10) Has there been an infarction of brain tissue, cerebral and subarachnoid haemorrhage, cerebral embolism and cerebral thrombosis? ***YES / NO*** If “Yes”, please provide details.

11) Has the patient suffered from any complications arising from or related to Stroke (e.g. hypertension, epilepsy, etc.)? ***YES / NO*** If “Yes”, please provide details, including date of diagnosis and treatment prescribed.

12) a) Please describe treatment prescribed, including any operations performed with date(s).

b) Please provide in full detail the Rehabilitation programs (if any) and the results arising from such programs. If the patient is not undergoing or has never undergone any Rehabilitation programs, please advise the reasons for such arrangement.

13) What is the prognosis?

14) Please describe and elaborate on the nature and severity of the patient's **Physical** disability and limitation.

15) Please describe and elaborate on the nature and severity of the patient's **Mental** disability and limitation.

16) a) What are the daily activities of the patient?

b) How has the patient's present condition improved since the day he / she was diagnosed with Stroke?

17) What are the activities / duties that the patient is able to perform for an occupation (e.g. answering calls, writing notes, typing, etc.)?

18) Is the patient still on follow-up? ***YES / NO***

a) If "Yes", please advise date of last and next appointment:

b) If "No", please advise date of discharge:

19) Are you aware of any other doctors (in Singapore or overseas) whom the patient consulted for the above illness or any other cardiovascular or neurological diseases? ***YES/NO*** If “Yes”, please advise:

Name of Doctor and Name & Address of Clinic / Hospital	Date of First & Last Consultation	Reason & Treatment

20) Had the patient ever been hospitalised before? ***YES / NO*** If “Yes”, please advise:

Name of hospital	Reason & Treatment	Date of Admission & Discharge

21) Please state and attach copies of all reports such as specialist or hospital reports and investigation reports (biopsy, histopathology, cytology, X-rays, CT and MRI scans, other imaging studies, laboratory evidence, etc.).

22) Do you have any other information that may be important for our assessment of the claim? ***YES / NO*** If “Yes”, please provide details.

Signature of Physician : ....

Name of Physician : ....

Designation : ……………………………………………………….

Clinic’s Address & Stamp: ....…

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Date : ....