



**Critical Illness Claim - Doctor's Statement  
Deafness (Loss of Hearing) /  
Cavernous Sinus Thrombosis Surgery or Cochlear Implant Surgery**

**SECTION 2 – DOCTOR'S STATEMENT** (to be completed by the attending doctor at claimant's expense)

<b>A) Patient's Particulars</b>									
Name of Patient	Gender								
NRIC/FIN or Passport No.	Date of Birth (ddmmyyyy) <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								
<b>B) Patient's Medical Records</b>									
1) Please state over what period does the Hospital/Clinic's record extend?									
(i) Date of First Consultation (ddmmyyyy)	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								
(ii) Date of Last Consultation (ddmmyyyy)	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								
(iii) Number of consultations during the above period:									
(iv) Name of hospital/clinic and Reason for consultations (with dates):									
2) Are you the patient's usual medical doctor? <span style="float:right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>									
If "Yes", since when? (ddmmyyyy)	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								
If "No", please provide name and address of the patient's regular doctor.									
3) Was the patient referred to you? <span style="float:right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>									
If "Yes", please provide:									
(i) Date referred (ddmmyyyy)	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								
(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? <span style="float:right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>									
(i) Date referred (ddmmyyyy)	<table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								
(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. cyst, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, anaemia, etc) If "Yes", please provide:	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<table style="width: 100%; border: none;"> <tr> <td style="border: none;"><u>Details of symptoms</u></td> <td style="border: none;"><u>Exact diagnosis</u></td> <td style="border: none;"><u>Date diagnosed</u></td> <td style="border: none;"><u>Treatment</u></td> </tr> </table>	<u>Details of symptoms</u>	<u>Exact diagnosis</u>	<u>Date diagnosed</u>	<u>Treatment</u>	
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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>Deafness (Loss of Hearing)</b> condition:											
(i) Date the patient First consulted you for this condition (ddmmyyyy)	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>										
(ii) Details of symptom(s) presented during the First consultation, and date these symptoms First started.											
(iii) What is the underlying cause(s) of the symptoms?											
(iv) Exact Diagnosis of the condition:											
ICD-10 Code (if applicable):											
(v) Date of First Diagnosis (ddmmyyyy)	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>										
(vi) Date the patient first became aware of the illness/condition (ddmmyyyy)	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>										

2) Please provide dates and details of investigation performed for the diagnosis and attach a copy of all relevant test reports (including audiometric and sound-threshold tests) which confirmed the diagnosis.

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

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4) Is there total loss of hearing in both the ears? If "Yes", please state:  Yes  No

(i) The current hearing ability in both ears (in decibels):  
 Right Ear  Left Ear

(ii) Please provide copies of audiogram and sound-threshold tests.

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5) Is there a total loss of at least 80 decibels in all frequencies of hearing in both ears?  Yes  No  
 If "Yes", please provide supporting evidence (including audiometric and sound-threshold tests results).

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6) Is the hearing loss irreversible in both ears?  Yes  No

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7) Is there any surgery available that could reinstate hearing in either or both ears?  Yes  No  
 If "Yes", please state:

(i) Nature of surgery:

(ii) What is the best possible corrected hearing frequency for both ears?  
 Right Ear  Left Ear

(iii) Has such surgery been recommended to the patient?  Yes  No

(iv) Tentative Date of Surgery (ddmmyyyy)

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8) Is the condition resulting from drug induced partial hearing loss?  Yes  No  
 If "Yes", please provide details.

9) Has the patient undergone **surgery for Cavernous Sinus Thrombosis**?  Yes  No  
 If "No", please proceed to **Question 10**.  
 If "Yes", please advise the following:

(i) Date of diagnosis of Cavernous Sinus Thrombosis (ddmmyyyy) 

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(ii) Was the surgery performed for Cavernous Sinus Thrombosis? If "Yes", please state:  Yes  No

(a) Type of Surgery performed:

(b) Date of Surgery was performed (ddmmyyyy) 

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(c) Please attach copies of Operation Report and diagnostic test report.

10) Has the patient undergone **Cochlear Implant Surgery**?  Yes  No  
 If "No", please proceed to **Section D**.  
 If "Yes", please advise the following:

(i) Was there permanent damage to the cochlea or auditory nerve?  Yes  No

(ii) Was a Cochlear Implant Surgery performed? If "Yes", please state  Yes  No

(a) Date it was performed (ddmmyyyy) 

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(b) Please attach copies of Operation Report.

(c) Was the surgery performed considered medically necessary by the ENT Specialist?  Yes  No

**D) Other Information**

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

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2) Is the loss of hearing in any way related or due to congenital anomaly or defect?  Yes  No  
 If "Yes", please provide details including date of diagnosis.

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3) Is there anything in the patient's **lifestyle or personal medical history** which would have increased the risk of Loss of Hearing? If "Yes", please give details:  Yes  No

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

4) Is there anything in the patient's <b>family history</b> which would have increased the risk of Loss of Hearing? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> If "Yes", please give details: <table style="width: 100%; border: none;"> <tr> <td style="width: 25%; border-bottom: 1px solid black;"><u>Relationship with patient</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Nature of condition</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Age of onset</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Source of information</u></td> </tr> </table>	<u>Relationship with patient</u>	<u>Nature of condition</u>	<u>Age of onset</u>	<u>Source of information</u>
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5) Please describe and elaborate on the nature and severity of the patient's disability and limitation, if any.				
6) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for <b>Ear condition</b> or any other related diseases? If "Yes", please give details: <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <table style="width: 100%; border: none;"> <tr> <td style="width: 45%; border-bottom: 1px solid black;"><u>Name of doctor and Address of hospital/clinic</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Date first &amp; last consulted</u></td> <td style="width: 30%; border-bottom: 1px solid black;"><u>Reasons for consultation</u></td> </tr> </table>	<u>Name of doctor and Address of hospital/clinic</u>	<u>Date first &amp; last consulted</u>	<u>Reasons for consultation</u>	
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7) Please enclose copies of all reports including specialist or hospital reports, audiogram and sound-threshold tests, Cerebral Angiography, CT scans, MRI, other imaging studies, laboratory evidence, surgical report, etc. that are available.				

<b>E) 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)	