* S U P D O C *

AVIVA

Critical Illness Claim - Doctor's Statement
Major Cancers / Carcinoma in-situ / Early Cancer

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 **Cancer**:

(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) 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) | | | | | | | | |

(vi) Date the patient 1st became aware of the 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) What is the primary and exact site of the tumour?

5) What is the staging of the tumour?

6) Please state the tumour classification (e.g. TNM classification, etc.).

7) Please confirm:

(i) Was the disease completely localized? ❒ Yes ❒ No

(ii) Was there invasion of adjacent tissues? ❒ Yes ❒ No

(iii) Were regional lymph nodes involved? ❒ Yes ❒ No

(iv) Were there distant metastases? ❒ Yes ❒ No

8) Did the patient undergo any surgery? If "Yes", please state: ❒ Yes ❒ No

a) Date of surgery (ddmmyyyy)

b) Nature of the surgery performed (e.g. mastectomy, hysterectomy, prostatectomy, gastrectomy, etc.)

c) Specify if there was full or partial resection (if applicable).

d) Reason(s) for performing the surgery.

e) Please provide copy of operation report and histology report.

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9) Did the patient undergo any other mode of treatment? (e.g. chemothereapy, radiotherapy, etc.). ❒ Yes ❒ No

If "Yes", please provide the following details.

Date of Treatment (ddmmyyyy)	Type of Treatment	Duration of Treatment	Patient's Response to the Treatment

10) Is the diagnosis Malignant Melanoma? ❒ Yes ❒ No

If "Yes", please provide full details of size, thickness (Breslow classification) and/or depth of invasion (Clark level)?

11) Is the diagnosis Gastro-Intestinal Stromal tumour (GIST)? If "Yes", please state: ❒ Yes ❒ No

(a) Tumour classification (TNM classification):

(b) Mitotic count (in HPFs):

12) Is the diagnosis Leukaemia? If "Yes", please state: ❒ Yes ❒ No

(a) Type of leukaemia:

(b) RAI Staging

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

D) Other Information

1) Was the tumour or cancer in any way related or in the presence of any Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) infection? ❒ Yes ❒ No

If "Yes", please state date HIV/AIDS was diagnosed. (ddmmyyyy) | | | | | | | | |

2) Was the tumour or cancer in any way caused directly or indirectly by alcohol or drug abuse? ❒ Yes ❒ No

If "Yes", please provide details.

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

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

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4) Is there anything in the patient's **family history** which would have increased the risk of Cancer? ❒ Yes ❒ No

If "Yes", please give details:

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

5) Has active treatment and therapy now been rejected in favour of relief of symptoms? ❒ Yes ❒ No

If "Yes", please provide full details why this view / course of action is taken.

6) Can you confirm that the advent of death is highly probable within:

(i) six (6) months? ❒ Yes ❒ No

(ii) twelve (12) months? ❒ Yes ❒ No

If "Yes", please describe and provide relevant medical reports that support this view.

7) Please describe and elaborate on the nature and severity of the patient's disability and limitation, if any.

8) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for Cancer 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) Please enclose a copy of all reports including specialist or hospital reports, biopsy reports, cytology reports, histology reports, x-rays, CT scans, other imaging studies, laboratory evidence, surgical report, 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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