* S U P D O C *

AVIVA

Living Benefit Claim - Doctor's Statement
Hospital Care Benefits for Child

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/BC/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, any illness or any congenital condition? If "Yes", please provide: ❒ Yes ❒ No

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?

C) Details of Illness

1) Please **tick (√)** the box the condition to which this doctor's report relates:

- ❒ Admission into neonatal intensive care unit (NICU) or high dependency unit (HDU)
- ❒ Hospitalisation due to Hand, Foot and Mouth Disease
- ❒ Incubation of the newborn child for more than 3 consecutive days immediately following birth
- ❒ Phototherapy or Blood Transfusion for severe neonatal jaundice
- ❒ Premature birth requiring neo-natal ICU/HDU

2) Please provide details of the 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) | | | | | | | | |

3) Was the child born prematurely? If "Yes", please provide the details. ❒ Yes ❒ No

(i) Gestation period _____ weeks (ii) Birth weight _____ grams

4) Was the child incubated for more than 3 consecutive days immediately following birth? ❒ Yes ❒ No

If "Yes", please state the period of incubation (ddmmyyyy)

From | | | | | | | | | to | | | | | | | | |

5) Was the child admitted to a neonatal intensive care unit (NICU)? ❒ Yes ❒ No

If "Yes", please state the period of confinement (ddmmyyyy)

From | | | | | | | | | to | | | | | | | | |

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6) Was the child admitted to a high dependency unit (HDU)? ❒ Yes ❒ No

If "Yes", please state the period of confinement (ddmmyyyy)

From | | | | | | | | | to | | | | | | | | |

7) Did the child requires hospitalisation for at least 3 consecutive days for treatment with phototherapy or blood transfusion within 30 days after birth? If "Yes", please confirm the following: ❒ Yes ❒ No

(i) Was there presence of neonatal jaundice? ❒ Yes ❒ No

If "Yes", please state the **total serum bilirubin level**:

(ii) For term infant, at or greater than 37 weeks gestational age:

(a) 25 to 72 hours after birth: | | µ mol/L (micromol/litre)

(b) More than 72 hours after birth: | | µ mol/L (micromol/litre)

(c) Please provide copy of diagnostic and blood test results.

(ii) For pre-matured infants, at less than 37 weeks gestational age:

(a) 25 to 72 hours after birth: | | µ mol/L (micromol/litre)

(b) More than 72 hours after birth: | | µ mol/L (micromol/litre)

(c) Please provide copy of diagnostic and blood test results.

8) Was the child hospitalised for **Hand, foot and mouth (HFM) disease**? ❒ Yes ❒ No

If "No", please proceed to **question 9**.

If "Yes", please state:

(i) Date of admission (ddmmyyyy) | | | | | | | | |

(ii) **Provisional diagnosis** on admission.

(iii) Were there any viral studies done to confirm the diagnosis of HFM Disease? ❒ Yes ❒ No

If "Yes", please indicate the investigations carried out and their results.

(iv) Did the patient suffer from any form of viral encephalitis or myocarditis during this admission? ❒ Yes ❒ No

If "Yes", please provide documented evidence of the presence of the encephalitis or myocarditis.

(v) Was positive isolation of the causative virus carried out during this admission? ❒ Yes ❒ No

(vi) Was Coxsackie A17 or Entenovirus 71 specifically isolated during the viral studies? ❒ Yes ❒ No

(vii) Did the patient suffer any neurological deficit after the date of diagnosis of the HFM Disease? ❒ Yes ❒ No

If "Yes", please state:

(a) Neurological deficits suffered.

(b) Was there evidence of neurological deficit that lasted at least 30 days after the date of diagnosis of the HFM Disease was established? Please elaborate. ❒ Yes ❒ No

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9) What is the underlying cause(s) of the condition?

10) 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:

11) Was the patient's mother 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.

12) 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)

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

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

13) 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

14) 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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