



**Living Benefit Claim - Doctor's Statement  
Pregnancy Complications Benefit – Pre-Eclampsia or Eclampsia**

**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 Reasons 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. tumour, diabetes, hypertension, hyperlipidaemia, anaemia etc.)? If "Yes", please provide: <u>Details of symptoms</u> <u>Exact diagnosis</u> <u>Date diagnosed</u> <u>Treatment</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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>	

**C) Details of Illness**

1) Please provide details of <b>Pre-Eclampsia or Eclampsia</b> condition.											
(i) Date the patient First consulted you for this condition (ddmmyyy)	<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> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
(ii) Details of symptom(s) presented at first consultation, and date these symptoms <b>first</b> started.											
(iii) Exact Diagnosis of the condition:  ICD-10 Code (if applicable):											
(iv) Date of <b>First</b> diagnosis (ddmmyyy)	<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> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
(v) Date the patient <b>First</b> became aware of this condition (ddmmyyy)	<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> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										

2) Was there hypertension developing after 20 weeks of pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No										
3) What were the highest BP readings recorded on 2 successive measurements of at least 6 hours apart post 20 weeks of pregnancy?											
(a) 1 <sup>st</sup> Reading Taken: Date (ddmmyyyy), time and its reading	Time: _____      Systolic: _____ mmHg										
<table border="1" style="display: inline-table; border-collapse: collapse; width: 100px; height: 20px; text-align: center;"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>											Diastolic: _____ mmHg
(b) Next Reading Taken: Date (ddmmyyyy), time and its reading	Time: _____      Systolic: _____ mmHg										
<table border="1" style="display: inline-table; border-collapse: collapse; width: 100px; height: 20px; text-align: center;"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>											Diastolic: _____ mmHg
4) Was there associated proteinuria and increased levels of creatinine? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span>											
If "Yes", please provide details and test result.											
Please furnish copies of investigation and lab reports.											
5) Was this pregnancy conceived through any of the following fertility treatments:											
(a) Vitro Fertilization (IVF) <input type="checkbox"/> Yes <input type="checkbox"/> No											
(b) Intra-Cytoplasmic Sperm (ICSI) <input type="checkbox"/> Yes <input type="checkbox"/> No											
(c) Intrauterine Insemination (IUI) <input type="checkbox"/> Yes <input type="checkbox"/> No											
(d) Intracervical Insemination (ICI) <input type="checkbox"/> Yes <input type="checkbox"/> No											
(e) If none of the above, please specify the fertility treatment that the patient has received:											
6) Was the patient carrying 5 or more babies in this pregnancy? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span>											
If "No", please state the <b>number</b> of babies that the patient has carried in this single pregnancy.											
7) Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span>											
If "Yes", please provide the date of HIV/AIDS diagnosis (dd/mm/yyyy)	<table border="1" style="display: inline-table; border-collapse: collapse; width: 100px; height: 20px; text-align: center;"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>										
8) Is the diagnosis related to self-inflicted injury, suicide or attempted suicide? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span>											
9) Is the diagnosis related to any deliberate misuse of any drugs or alcohol? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span>											
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? <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span>											
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 & Official Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	