* S U P D O C *

AVIVA

Critical Illness Claim - Doctor's Statement
Special Benefit - Severe Rheumatoid Arthritis

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, frequent falls, etc.) 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?

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 **Severe Rheumatoid Arthritis**:

(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):

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(v)	Date of **First** diagnosis (ddmmyyyy)	
(vi)	Date the patient **First** became aware of the illness/condition (ddmmyyyy)	

2)	Is there evidence of widespread joint destruction with major clinical deformity of the joint areas of:		
	i) Hands?	❒ Yes	❒ No
	ii) Wrists?	❒ Yes	❒ No
	iii) Elbows?	❒ Yes	❒ No
	iv) Spine?	❒ Yes	❒ No
	v) Knee?	❒ Yes	❒ No
	vi) Ankle?	❒ Yes	❒ No
	vii) Feet?	❒ Yes	❒ No
	If "Yes" to any of the above, please provide details to your answer.		
3)	Has the patient suffered from any of the following symptoms?		
	i) Morning stiffness?	❒ Yes	❒ No
	ii) Symmetric arthritis?	❒ Yes	❒ No
	iii) Presence of rheumatoid nodules?	❒ Yes	❒ No
4)	Is there evidence of elevated titres of rheumatoid factors?	❒ Yes	❒ No
5)	Please state the results of investigations done and attach a copy of the test reports showing elevated titres of rheumatoid factors.		
6)	Please provide details of current **treatment**, including name and dosage of medication, occupational or physical therapy (if any).		

7) Has the patient ever been hospitalised for Severe Rheumatoid Arthritis or its related symptoms or complications? ❒ Yes ❒ No

If "Yes", please advise:

Date of hospitalisation	Reasons for hospitalisation	Treatment received (including operation, if any)	Name of doctor/surgeon & Address of hospital

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D) Other Information

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

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

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

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

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

4) 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.

5) 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.

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

7) Please describe and elaborate on the nature and severity of the patient's **mental** disability and limitations, including the degree of cognitive and/or intellectual impairment.

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8)	Is the patient's condition or surgery performed in any way related or due to:		
	i) AIDS, AIDS-related complex or infection by HIV?	❒ Yes	❒ No
	ii) Drug abuse or use of drug not prescribed by registered medical practitioner?	❒ Yes	❒ No
	iii) Alcohol abuse or misuse?	❒ Yes	❒ No
	iv) Congenital anomaly or defect?	❒ Yes	❒ No
	v) Attempted suicide or self-inflicted injuries?		
	If "Yes" for any of the above, please provide the details including diagnosis date, name of doctor and clinic who first diagnosed the patient with HIV, AIDS, drug abuse, alcohol abuse or congenital anomaly. Please provide copy of test result.		
9)	Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for Severe Rheumatoid Arthritis or any possible related illness, especially any consultations concerning neruological symptoms or complaints, however minor in nature? If "Yes", please give details: Name of doctor and Address of hospital/clinic — Date of first & last consulation — Reasons for consultation	❒ Yes	❒ No
10)	Please provide us with any other additioanl information that will enable the Company to assess this claim.		
11)	Please enclose a copy of all reports including specialist or hospital reports X-ray, magnetic resonance imaging (MRI) report, 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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