* S U P D O C *

AVIVA

Critical Illness Claim - Doctor's Statement
Special Benefit - Diabetic Complications

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. tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, 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 **Diabetic Complications:**

(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 condition: (ddmmyyyy)	

2) Name and address of the doctor who **First** diagnosed the medical condition.

3) Name and address of doctor that the patient is seeing for management of his/her diabetes.

4) Please provide details of recent blood sugar levels and date of assessment (dd/mm/yyyy).

5) Is there evidence of Diabetic Retinopathy? If "Yes", please provide the following details. ❒ Yes ❒ No

(i) Please **circle** which of the eye is affected by diabetic retinopathy?	**Left Eye**	**Right Eye**
(ii) Using the Snellen eye chart, what is the best possible corrected visual acuity of both eyes? **Date of test** (dd/mm/yyyy)	Left Eye	Right Eye

(iii) Does the patient require laser treatment for his/her diabetic retinopathy? ❒ Yes ❒ No

(iv) If laser treatment had been given, please state the date of such treatment (dd/mm/yyyy).

(v) Is such treatment absolutely necessary? If "No", please specify what alternative treatment is available for the patient's condition. ❒ Yes ❒ No

(vi) Please provide results of investigations done and attach copies of the fluorescent fundus angiography report.

6) Is there evidence of Diabetic Nephropathy? If "Yes", please provide the following details. ❒ Yes ❒ No

(i) Is there decreased renal function of less than eGFR less than 30 ml/min/1.73m^2? ❒ Yes ❒ No
Please provide the eGFR readings, including dates of assessment.

(ii) Is there ongoing proteinuria greater than 300 mg/24 hours? ❒ Yes ❒ No
Please provide the proteinuria readings, including dates of assessment.

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(iii) Please provide the results of investigations done and attach copies of renal function test and urinalysis reports.

7) Has the patient undergo any amputation due to diabetes? If "Yes", please provide the following details. ❒ Yes ❒ No

(i) The underlying cause for the amputation.

(ii) The site/area of amputation.

(iii) The name and type of surgery patient has undergone.

(iv) Exact date of surgery (dd/mm/yyyy) | | | | | | | | |

(v) The name and address of hospital where the surgery was performed and provide copy of operation report.

D) Other Information

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

2) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for the medical condition or **any possible related illness**? ❒ Yes ❒ No

If "Yes", please give details:

Name of doctor and Address of hospital/clinic	Date of first & last consulation	Reasons for consultation

3) Has the patient ever been hospitalised for the medical condition **or** its related symptoms or complications? If "Yes", please advise: ❒ Yes ❒ No

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

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4) Is there anything in the patient's **personal medical history** or **family history** which would have increased the risk of the Fulminant Hepatitis / Hepatitis with Cirrhosis or its related illness? If "Yes", please give details:	❒ Yes ❒ No
Exact diagnosis / Date of diagnosis / Name of doctor & address of hospital/clinic	
5) Please describe the nature and severity of the patient's **physical** and **mental** disability and limitation, if any.	
8) Please provide us with any other additioanl information that will enable the Company to assess this claim.	
9) Please enclose a copy of all reports including specialist or hospital reports, liver biopsy, liver/abdominal ultrasound and radiological report, endoscopy results, laboratory evidence (including serial liver function tests), 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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