



Critical Illness Claim – Doctor’s Statement Aplastic Anaemia

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) <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) Patient’s Medical Records									
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? <input type="checkbox"/> Yes <input type="checkbox"/> No									
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? <input type="checkbox"/> Yes <input type="checkbox"/> No									
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? <input type="checkbox"/> Yes <input type="checkbox"/> No									
(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. cyst, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, blood transfusion, 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 smoking , including the duration of smoking habits, number of cigarettes smoked per day and source of this information: <div style="display: flex; justify-content: space-around;"> <u>No. of years of smoking</u> <u>No. of sticks per day</u> <u>Source of information</u> </div>	
9) Please give details of the patient's habits in relation to alcohol consumption , including the amount of the alcohol consumption, frequency and source of this information: <div style="display: flex; justify-content: space-around;"> <u>Type of alcohol</u> <u>Quantity per consumption</u> <u>Frequency (per week / month, etc.)</u> <u>Source of information</u> </div>	

C) Details of Illness											
1) Please provide details of Aplastic Anaemia :											
(i) Date the patient First consulted you for this condition (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> <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 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)	<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>										
(vi) Date the patient First became aware of the illness/condition (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> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										

2) Name and address of the haematologist who First diagnosed the patient with Aplastic Anaemia.				
3) Please provide details of investigation performed (with dates) to establish the diagnosis of Aplastic Anaemia (e.g. bone marrow aspirate and biopsy, X-ray, computed tomography scans, ultrasound imaging tests, laboratory tests including antibodies, complete blood count, liver function tests, etc.). Also, please attach a copy of all the relevant test reports.				
4) What is the likely cause of the patient's Aplastic Anaemia, if known (e.g. exposure to drugs, infection, autoimmune disease, heredity)?				
5) Is the patient's condition in any way attributable to Human Immunodeficiency virus (HIV) infection or Acquired Immune Deficiency Syndrome (AIDS)? If "Yes", please provide details. <input type="checkbox"/> Yes <input type="checkbox"/> No				
6) Was the patient's Aplastic Anaemia due to: (i) Acute reversible bone marrow failure? <input type="checkbox"/> Yes <input type="checkbox"/> No (ii) Chronic persistent bone marrow failure? <input type="checkbox"/> Yes <input type="checkbox"/> No				
7) Was there: (i) Anaemia? <input type="checkbox"/> Yes <input type="checkbox"/> No (ii) Neutropenia? <input type="checkbox"/> Yes <input type="checkbox"/> No (iii) Thrombocytopenia? <input type="checkbox"/> Yes <input type="checkbox"/> No				
8) Does the patient require or has received the following treatment: (i) Blood product transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No (ii) Marrow stimulating agents? <input type="checkbox"/> Yes <input type="checkbox"/> No (iii) Immunosuppressive agents? <input type="checkbox"/> Yes <input type="checkbox"/> No (iv) Bone marrow transplantation? <input type="checkbox"/> Yes <input type="checkbox"/> No				
9) Please provide details of treatment administered, including date/period of treatment, name and address of attending doctors.				
10) Has the patient ever been hospitalised for Aplastic Anaemia or its related symptoms or complications? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please advise: <table style="width: 100%; border: none;"> <tr> <td style="width: 25%;"><u>Date of hospitalisation</u></td> <td style="width: 25%;"><u>Reasons for hospitalisation</u></td> <td style="width: 25%;"><u>Treatment received (including operation, if any)</u></td> <td style="width: 25%;"><u>Name of doctor/surgeon & Address of hospital</u></td> </tr> </table>	<u>Date of hospitalisation</u>	<u>Reasons for hospitalisation</u>	<u>Treatment received (including operation, if any)</u>	<u>Name of doctor/surgeon & Address of hospital</u>
<u>Date of hospitalisation</u>	<u>Reasons for hospitalisation</u>	<u>Treatment received (including operation, if any)</u>	<u>Name of doctor/surgeon & Address of hospital</u>	

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 Aplastic Anaemia? If "Yes", please give details:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Exact diagnosis</u>	<u>Date of diagnosis</u> <u>Name of doctor & address of hospital/clinic</u>
3) Is there anything in the patient's family history which would have increased the risk of Aplastic Anaemia? If "Yes", please give details:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Relationship with patient</u>	<u>Nature of condition</u> <u>Age of onset</u> <u>Source of information</u>
4) Has active treatment and therapy now been rejected in favour of relief of symptoms? If "Yes", please provide full details why this view / course of action is taken.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5) Can you confirm that the advent of death is highly probable within: (i) six (6) months? (ii) twelve (12) months? If "Yes", please describe and provide relevant medical reports that support this view.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
6) Please describe and elaborate on the nature and severity of the patient's physical and mental disability and limitation, if any.	
7) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for Aplastic Anaemia or any possible related illness ? If "Yes", please give details:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Name of doctor and Address of hospital/clinic</u>	<u>Date of first & last consultation</u> <u>Reasons for consultation</u>

8) Please provide us with any other additional information that will enable the Company to assess this claim.

9) Please enclose a copy of all reports including specialist or hospital reports, bone marrow aspirate and biopsy, computed tomography scans, ultrasound imaging tests, laboratory tests including antibodies, complete blood count, liver function tests, 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 & Official Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	