



**Critical Illness Claim - Doctor's Statement
Coma / Severe Epilepsy**

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:									

<p>2) Please provide full details and results of all investigation (with dates) performed for the diagnosis and attach a copy of all relevant test reports which confirmed the diagnosis.</p>
<p>3) Name and address of the doctor who First diagnosed the patient with this condition.</p>
<p>4) Was the coma a result of an accident, attempted suicide, or self-inflicted act? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide full details, and attach a copy of the police report if it was reported to the police.</p>
<p>5) Was the coma resulted from alcohol or drug abuse, or was it a medically induced coma? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide full details (e.g. result of blood alcohol concentration, name of drugs, quantity consumed, reasons for the medically induced coma, etc.)</p>
<p>6) Was the coma in any way related or due to congenital anomaly or defect? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please elaborate.</p>
<p>7) How many hours was the patient in a state of coma, with no response to external stimuli? <input type="text"/> hours</p>
<p>8) Was the patient put on life support measures? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please advise <u>date</u> the patient was put on life support measures and <u>details</u> of such life support measures.</p>

D) Other Information			
1) What is the prognosis of the patient?			
2) Has the patient previously suffered from the conditions leading to the Coma?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "Yes", please provide details including diagnosed date, exact diagnosis, treatment prescribed, name and address of attending doctor.			
3) Is there anything in the patient's lifestyle or personal medical history which would have increased the risk of this condition? If "Yes", please give details:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Type of Lifestyle / Exact diagnosis</u>	<u>Date of diagnosis</u>	<u>Name of doctor & Address of hospital/clinic</u>	
4) Is there anything in the patient's family history which would have increased the risk of this condition? 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>
5) 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
6) Can you confirm that the advent of death is highly probable within:			
(i) six (6) months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
(ii) twelve (12) months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "Yes", please describe and provide relevant medical reports that support this view.			

7) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for the Coma or Epilepsy condition or any other related diseases? If "Yes", please give details:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
<table style="width: 100%; border: none;"> <tr> <td style="border: none;"><u>Name of doctor and Address of hospital/clinic</u></td> <td style="border: none;"><u>Date first & last consulted</u></td> <td style="border: none;"><u>Reasons for consultation</u></td> </tr> </table>	<u>Name of doctor and Address of hospital/clinic</u>	<u>Date first & last consulted</u>	<u>Reasons for consultation</u>	
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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, magnetic resonance imaging, computerised tomography or other reliable imaging techniques, 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 & Official Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	