* S U P D O C *

AVIVA

Critical Illness Claim - Doctor's Statement
Major Organ / Bone Marrow Transplantation

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. anaemia, cyst, 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 any **major organ failure necessitating the organ transplantation**:

(i) Date of first consultation for this condition (ddmmyyyy)

(ii) Details of symptom(s) presented during the First consultation, and date these symptoms First started.

(iii) What is the underlying cause(s) of the symptoms?

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(iv) Exact Diagnosis of the underlying disease leading to the major organ transplantation:

ICD-10 Code (if applicable):

(v) Date when illness/condition necessitating organ transplant was First diagnosed (ddmmyyyy)

(vi) Date the patient first became aware of the illness/condition requiring transplant (ddmmyyyy)

2) Please provide dates and details of **investigation** performed for the diagnosis and **attach** a copy of all relevant test reports that confirmed the diagnosis.

3) Name and address of the doctor who **First** diagnosed the patient with the illness/condition necessitating the organ transplant.

4) Was the patient a recipient of a human bone marrow transplant? ❒ Yes ❒ No

If "Yes", please state:

(i) Date of the human bone marrow transplant (ddmmyyyy):

(ii) Whether there was total bone marrow ablation prior to using haematopoietic stem cells? ❒ Yes ❒ No

(iii) Any additional comments/information:

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5) Was the patient a recipient of the major organ transplant? ❒ Yes ❒ No

If "Yes", please advise:

(i) Date of the organ transplant (ddmmyyyy): | | | | | | | | |

(ii) Name of the transplanted organ:

(iii) Whether the entire organ *or* part of the organ was transplanted? ❒ Entire ❒ Part

(iv) Was there irreversible end-stage failure of the relevant organ that resulted in the transplant? ❒ Yes ❒ No

If "Yes", please elaborate with supporting evidence.

(v) What medical treatment or replacement therapy had the patient been receiving prior to the transplantation (e.g. dialysis, blood transfusions, etc)?

(vii) Date such treatment commence (ddmmyyyy): | | | | | | | | |

(vii) Date the patient was on the waiting list for the operation (ddmmyyyy): | | | | | | | | |

6) Was it the first graft? ❒ Yes ❒ No

If "No", please give date of the first graft (ddmmyyyyy): | | | | | | | | |

7) Name and address of the **surgeon** who performed the transplant and the **hospital** where the surgery was performed.

D) Other Information

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

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2) Is there anything in the patient's lifestyle or personal medical history which would have increased the risk of the major organ failure and/or bone marrow ablation? ❒ Yes ❒ No

If "Yes", please give details:

Exact diagnosis	Date of diagnosis	Name of doctor and Address of hospital/clinic

3) Is there anything in the patient's family history which would have increased the risk of the major organ failure and/or bone marrow ablation? If "Yes", please give details: ❒ Yes ❒ No

Relationship with patient	Nature of illness	Date of diagnosis	Source of information

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. ❒ Yes ❒ No

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 and mental disability and limitations, if any.

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7) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for the relevant **major organ failure** and/or **bone marrow ablation**, or any other possible **related illness**? If "Yes", please give details: ❒ Yes ❒ No

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

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

9) Please enclose copies of all reports including specialist or hospital reports, diagnostic test results, ultrasound, biopsy reports, surgical reports, laboratory evidence, 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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