



Critical Illness Claim - Doctor's Statement Pulmonary Hypertension

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;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></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;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> </tr> </table>									
(ii) Date of last consultation (ddmmyyyy)						<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></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;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></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;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></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;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></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. tumour, diabetes, hypertension, heart or asthma, etc.)? If “Yes”, please provide:	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; border-bottom: 1px solid black;"><u>Details of symptoms</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Exact diagnosis</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Date diagnosed</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Treatment</u></td> </tr> </table>	<u>Details of symptoms</u>	<u>Exact diagnosis</u>	<u>Date diagnosed</u>	<u>Treatment</u>	
<u>Details of symptoms</u>	<u>Exact diagnosis</u>	<u>Date diagnosed</u>	<u>Treatment</u>		
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:					
<u>No. of years of smoking</u>	<u>No. of sticks per day</u>	<u>Source of information</u>			
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.					
<u>Type of alcohol</u>	<u>Quantity per Consumption</u>	<u>Frequency (per week / month, etc.)</u>	<u>Source of information</u>		

C) Details of Illness

1) Please provide details of Pulmonary Hypertension condition:											
(i) Date the patient First consulted you for this condition (ddmmyyy)	<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 (ddmmyyy)	<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 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> </tr> </table>								
2) Name and address of the doctor who first diagnosed the patient of this illness/condition.									
3) Is the pulmonary hypertension due to primary or secondary causes? Please elaborate.									
4) Is the disease associated with any underlying causes or conditions, or related to any congenital condition? If "Yes", please provide details: <input type="checkbox"/> Yes <input type="checkbox"/> No									
5) Is the right ventricle of the heart enlarged? <input type="checkbox"/> Yes <input type="checkbox"/> No Please attach a copy of echocardiogram report. If "Yes", please advise date of first detection of the enlargement (ddmmyyyy)									
6) Was cardiac catheterisation performed to establish the diagnosis of pulmonary hypertension? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", Please attach a copy of echocardiogram report.									
7) Please provide details of investigation performed, with dates (e.g. Chest X-ray, echocardiogram, doppler study, CT scan, ventilation-perfusion scan, etc.)									
Please attach a copy of the above investigations reports.									
8) (i) Based on the patient's cardiac/physical impairment, please advise the class of impairment according to the New York Heart Association Classification of Cardiac Impairment? Class _____									
(ii) Please describe in detail the current symptoms.									

(iii) Is such impariment likely to be permanent? Yes No
 If "Yes", please explain.

9) What treatment has been administered?

10) Please provide details of **current** treatment.

11) Has transplantation been considered? Yes No
 If "Yes", please provide full details.

12) Is the patient still on follow-up at your hospital / clinic? Yes No
 If "Yes", please advise date of next appointment (ddmmyyyy)

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 If "No", please state date of discharge (ddmmyyyy)

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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 **Pulmonary Hypertension or any possible related illness**? Yes No
 If "Yes", please give details:

<u>Name of doctor and Address of hospital/clinic</u>	<u>Date of first & last consulation</u>	<u>Reasons for cosultation</u>

3)	Has the patient ever been hospitalised for the Pulmonary Hypertension or its related symptoms or complications? If "Yes", please advise:	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	<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>		
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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 Pulmonary Hypertension? If "Yes", please give details:	<input type="checkbox"/> Yes	<input type="checkbox"/> No				
	<table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><u>Exact diagnosis</u></td> <td style="width: 33%;"><u>Date of diagnosis</u></td> <td style="width: 34%;"><u>Name of doctor & address of hospital/clinic</u></td> </tr> </table>	<u>Exact diagnosis</u>	<u>Date of diagnosis</u>	<u>Name of doctor & address of hospital/clinic</u>			
<u>Exact diagnosis</u>	<u>Date of diagnosis</u>	<u>Name of doctor & address of hospital/clinic</u>					
5)	Please describe the nature and severity of the patient's physical and mental disability and limitation, if any.						
6)	Please provide us with any other additional information that will enable the Company to assess this claim.						
7)	Please enclose a copy of all reports including specialist or hospital reports, echocardiogram, dopple study, 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)							