



**Living Benefit Claim - Doctor's Statement
Hospital Care Benefits for Child**

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/BC/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, any illness or any congenital condition? 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?	

C) Details of Illness

1) Please tick (✓) the box the condition to which this doctor's report relates:																	
<input type="checkbox"/> Admission into neonatal intensive care unit (NICU) or high dependency unit (HDU) <input type="checkbox"/> Hospitalisation due to Hand, Foot and Mouth Disease <input type="checkbox"/> Incubation of the newborn child for more than 3 consecutive days immediately following birth <input type="checkbox"/> Phototherapy or Blood Transfusion for severe neonatal jaundice <input type="checkbox"/> Premature birth requiring neo-natal ICU/HDU																	
2) Please provide details of the condition.																	
(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> </tr> </table>																
(ii) Details of symptom(s) presented at first consultation, and date these symptoms first started.																	
(iii) Exact Diagnosis of the condition: ICD-10 Code (if applicable):																	
(iv) 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> </tr> </table>																
(v) 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>																
3) Was the child born prematurely? If "Yes", please provide the details.																	
(i) Gestation period <input style="width: 50px;" type="text"/> weeks	(ii) Birth weight <input style="width: 50px;" type="text"/> grams																
<input type="checkbox"/> Yes <input type="checkbox"/> No																	
4) Was the child incubated for more than 3 consecutive days immediately following birth?																	
<input type="checkbox"/> Yes <input type="checkbox"/> No																	
If "Yes", please state the period of incubation (ddmmyyyy)																	
From <table border="1" style="display: inline-table; width: 100px; 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> to <table border="1" style="display: inline-table; width: 100px; 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>																	
5) Was the child admitted to a neonatal intensive care unit (NICU)?																	
<input type="checkbox"/> Yes <input type="checkbox"/> No																	
If "Yes", please state the period of confinement (ddmmyyyy)																	
From <table border="1" style="display: inline-table; width: 100px; 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> to <table border="1" style="display: inline-table; width: 100px; 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>																	

6) Was the child admitted to a high dependency unit (HDU)? If "Yes", please state the period of confinement (ddmmyyyy) From <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> </table> to <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> </table>																	<input type="checkbox"/> Yes <input type="checkbox"/> No
7) Did the child requires hospitalisation for at least 3 consecutive days for treatment with phototherapy or blood transfusion within 30 days after birth? If "Yes", please confirm the following:	<input type="checkbox"/> Yes <input type="checkbox"/> No																
(i) Was there presence of neonatal jaundice? If "Yes", please state the total serum bilirubin level :	<input type="checkbox"/> Yes <input type="checkbox"/> No																
(ii) For term infant, at or greater than 37 weeks gestational age: (a) 25 to 72 hours after birth: <table border="1" style="display: inline-table; border-collapse: collapse; width: 60px; height: 25px; vertical-align: middle;"> </table> μ mol/L (micromol/litre) (b) More than 72 hours after birth: <table border="1" style="display: inline-table; border-collapse: collapse; width: 60px; height: 25px; vertical-align: middle;"> </table> μ mol/L (micromol/litre) (c) Please provide copy of diagnostic and blood test results.																	
(ii) For pre-matured infants, at less than 37 weeks gestational age: (a) 25 to 72 hours after birth: <table border="1" style="display: inline-table; border-collapse: collapse; width: 60px; height: 25px; vertical-align: middle;"> </table> μ mol/L (micromol/litre) (b) More than 72 hours after birth: <table border="1" style="display: inline-table; border-collapse: collapse; width: 60px; height: 25px; vertical-align: middle;"> </table> μ mol/L (micromol/litre) (c) Please provide copy of diagnostic and blood test results.																	
8) Was the child hospitalised for Hand, foot and mouth (HFM) disease ? If "No", please proceed to question 9 . If "Yes", please state:	<input type="checkbox"/> Yes <input type="checkbox"/> No																
(i) Date of admission (ddmmyyyy) <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> <td style="width: 20px; height: 20px;"> </td> </tr> </table>									(ii) Provisional diagnosis on admission.								
(iii) Were there any viral studies done to confirm the diagnosis of HFM Disease? If "Yes", please indicate the investigations carried out and their results.	<input type="checkbox"/> Yes <input type="checkbox"/> No																
(iv) Did the patient suffer from any form of viral encephalitis or myocarditis during this admission? If "Yes", please provide documented evidence of the presence of the encephalitis or myocarditis.	<input type="checkbox"/> Yes <input type="checkbox"/> No																
(v) Was positive isolation of the causative virus carried out during this admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No																
(vi) Was Coxsackie A17 or Entenovirus 71 specifically isolated during the viral studies?	<input type="checkbox"/> Yes <input type="checkbox"/> No																
(vii) Did the patient suffer any neurological deficit after the date of diagnosis of the HFM Disease? If "Yes", please state:	<input type="checkbox"/> Yes <input type="checkbox"/> No																
(a) Neurological deficits suffered.																	
(b) Was there evidence of neurological deficit that lasted at least 30 days after the date of diagnosis of the HFM Disease was established? Please elaborate.	<input type="checkbox"/> Yes <input type="checkbox"/> No																

9) What is the underlying cause(s) of the condition?

10) Was this pregnancy conceived through any of the following fertility treatments:

(a) Vitro Fertilization (IVF) Yes No

(b) Intra-Cytoplasmic Sperm (ICSI) Yes No

(c) Intrauterine Insemination (IUI) Yes No

(d) Intracervical Insemination (ICI) Yes No

(e) If none of the above, please specify the fertility treatment that the patient has received:

11) Was the patient's mother carrying 5 or more babies in this pregnancy? Yes No

If "No", please state the **number** of babies that the patient has carried in this single pregnancy.

12) Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? Yes No

If "Yes", please provide the date of HIV/AIDS diagnosis. (dd/mm/yyyy)

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11) Is the diagnosis related to self-inflicted injury, suicide or attempted suicide? Yes No

12) Is the diagnosis related to any deliberate misuse of any drugs or alcohol? Yes No

13) Is the diagnosis related to the use of unprescribed drugs where such drugs are required by the law to be prescribed by a registered medical doctor? Yes No

14) Please enclose a copy of all reports including specialist or hospital reports, laboratory evidence, surgical report, etc.

D) 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)	