



**Living Benefit Claim - Doctor's Statement
Pregnancy Complications Benefit – Fatty Liver of Pregnancy**

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%; border-collapse: collapse;"> <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> </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%; border-collapse: collapse;"> <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> </tr> </table>							
(ii) Date of last consultation (ddmmyyyy)						<table border="1" style="width:100%; border-collapse: collapse;"> <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> </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%; border-collapse: collapse;"> <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> </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%; border-collapse: collapse;"> <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> </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%; border-collapse: collapse;"> <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> </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, hyperlipidaemia, anaemia 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: <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 Fatty Liver of Pregnancy 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) Exact Diagnosis of the condition: ICD-10 Code (if applicable):											
(iv) 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>										
(v) Date the patient First became aware of 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>										

2) Was there acute liver failure? If "Yes", please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Was there persistent elevation of bilirubin above 150 umol/L (10mg/dL) for a period of at least 5 days? If "Yes", please state the readings taken for each day and provide investigation results to support the diagnosis.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4) Was there associate hepatic encephalopathy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5) Was there acute fatty liver? Please indicate the level of severity.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6) Does the patient have prior history of liver dysfunction? If "Yes", please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No
7) What is the underlying cause(s) of the fatty liver of pregnancy?	
8) Was this pregnancy conceived through any of the following fertility treatments: <ul style="list-style-type: none"> (a) Vitro Fertilization (IVF) <input type="checkbox"/> Yes <input type="checkbox"/> No (b) Intra-Cytoplasmic Sperm (ICSI) <input type="checkbox"/> Yes <input type="checkbox"/> No (c) Intrauterine Insemination (IUI) <input type="checkbox"/> Yes <input type="checkbox"/> No (d) Intracervical Insemination (ICI) <input type="checkbox"/> Yes <input type="checkbox"/> No (e) If none of the above, please specify the fertility treatment that the patient has received: 	
9) Was the patient carrying 5 or more babies in this pregnancy? If "No", please state the number of babies that the patient has carried in this single pregnancy.	<input type="checkbox"/> Yes <input type="checkbox"/> No

10) Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? If "Yes", please provide the date of HIV/AIDS diagnosis (dd/mm/yyyy)	<input type="checkbox"/> Yes <input type="checkbox"/> No								
	<table border="1" style="display: inline-table; border-collapse: collapse;"> <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>								
10) Is the diagnosis related to self-inflicted injury, suicide or attempted suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
11) Is the diagnosis related to any deliberate misuse of any drugs or alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
12) 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
13) 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)	