* S U P D O C *

Singlife

Critical Illness Claim - Doctor's Statement
Benign Brain Tumour /
Surgical Removal of Pituitary Tumour or Surgery for Subdural Haematoma

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. cyst, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, anaemia, 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 **Benign Brain Tumour** condition:

(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?

(iv) Exact Diagnosis of the condition:

ICD-10 Code (if applicable):

(v) Date of First Diagnosis (ddmmyyyy) | | | | | | | | |

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

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

3) Name and address of the doctor who **First** diagnosed the patient with this condition.

4) Has the tumour caused an increase in the intracranial pressure? ❒ Yes ❒ No

If "Yes", please provide details of the life threatening condition and/or neurological deficits suffered.

5) Please answer the following questions with regard to the **Benign Brain tumour**.

(If "**Yes**" to any question, please elaborate with supporting evidence such as magnetic resonance imaging, computerised tomography, or other reliable imaging techniques.)

(i) Is it life threatening? ❒ Yes ❒ No

(ii) Has it caused damage to the brain? ❒ Yes ❒ No

(iii) Has it been surgically removed? ❒ Yes ❒ No

If "Yes", please state:

(a) Type of Surgery:

(b) Date of Surgery (ddmmyyyy) | | | | | | | | |

(c) Tumour has been totally or partially removed? (Please tick) Totally removed ☐ Partially removed ☐

(d) Details of histology:

(iv) If the tumour is inoperable, has it caused any neurological deficits? ❒ Yes ❒ No

If "Yes", please state:

(a) Details of the neurological deficits suffered:

(b) Are the neurological deficits permanent? ❒ Yes ❒ No

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6) Is the patient's condition a cyst, a granuloma, vascular malformation in or of the arteries of the brain or haematomas? If "Yes", please state the type. ❒ Yes ❒ No

7) Is the patient's tumour of the pituitary or spinal cord? If "Yes", please state the type. ❒ Yes ❒ No

8) Has the patient undergone **surgery for Subdural Hematoma**? ❒ Yes ❒ No

If "No", please proceeds to **Section D.**

If "Yes", please advise the following:

(i) Was the cause of subdural hematoma a result of an accident ? ❒ Yes ❒ No

If "Yes", please state Date of Accident (ddmmyyyy)

Please provide details of how the accident occurred.

(ii) What were the investigations done to establish the diagnosis of subdural Hematoma? Please provide a copy of diagnostic reports (i.e. Magnetic Resonance Imaging (MRI), Computerised Tomography (CT) or others.)

(iii) Was the subdural hematoma drained through a Burr Hole Surgery to the head? ❒ Yes ❒ No

If "No", please state the treatment provided.

D) Other Information

1) Has the patient previously suffered from **Benign Brain Tumour** or any **related illness**? ❒ Yes ❒ No

If "Yes", please provide details including date of diagnosis, exact diagnosis, treatment prescribed, name and address of attending doctor.

2) Is there anything in the patient's **personal medical history** which would have increased the risk of this condition? If "Yes", please give details: ❒ Yes ❒ No

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

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3) Is there anything in the patient's **family history** which would have increased the risk of this condition? If "Yes", please give details: ❒ Yes ❒ No

Relationship with patient	Nature of condition	Age of onset	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 disability and limitation, if any.

7) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for the condition or any other related diseases? If "Yes", please give details: ❒ Yes ❒ No

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

8) Please enclose a copy of all reports including specialist or hospital reports, magnetic resonance imaging, computerised tomography or other reliable imaging techniques, biopsy reports, cytology reports, histology reports, 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 & Offical Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	