* S U P D O C *

Singlife

Critical Illness Claim - Doctor's Statement
Blindness (Loss of Sight) / Optic Nerve Atrophy with Low Vision

SECTION 2 – DOCTOR'S STATEMENT (to be completed by the attending doctor at claimant's expense)

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. glaucoma, 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 **Blindness (Loss of Sight)** condition:

(i) Date the patient First consulted you 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) What is the current visual acuity of both eyes using Snellen eye chart:

Right Eye | Left Eye

5) What is the current visual field in both eyes?

Right Eye | Left Eye

6) Is there any surgery available that could reinstate vision in either or both eyes? ❒ Yes ❒ No

If "Yes", please state:

(i) Nature of surgery:

(ii) What is the best possible corrected visual acuity of both eyes:

Right Eye | Left Eye

(iii) Has such surgery been recommended to the patient? ❒ Yes ❒ No

If "No", why not?

(iv) Tentative Date of Surgery (ddmmyyyy)

7) Has the patient sufferred from **Optic Nerve Atrophy with low vision**? ❒ Yes ❒ No

If "No", please proceed to **Question 8**.

If "Yes", please advise the following.

(i) How was the diagnosis of optic nerve atrophy established?

(ii) Are both eyes affected as a result of optic nerve atrophy? ❒ Yes ❒ No

If 'Yes", please provde details.

(iii) What is the best corrected visual acuity of both eyes, at present, using the Snellen eye chart?

Right Eye | Left Eye

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8) Is the visual loss permanent and irreversible in one or both eyes? ❒ Yes ❒ No

If "Yes", please indicate which eye is affected, and provide relevant medical reports that support this view.

9) Is the condition resulting from alcohol and/or drug misuse? ❒ Yes ❒ No

If "Yes", please provide details.

10) Is the blindness in any way related or due to congenital anomaly or defect? ❒ Yes ❒ No

If "Yes", please provide details including date of diagnosis.

D) Other Information

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

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

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

3) Has any of the patient's **family members** suffered from eye disease including blindness, cataract, or retinitis pigmentosa, etc.? If "Yes", please give details: ❒ Yes ❒ No

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

4) Please describe and elaborate on the nature and severity of the patient's disability and limitation, if any.

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5) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for eye disease 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

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

7) Please enclose copies of all reports including specialist (ophthalmologist) or hospital reports, CT scans, other imaging stdies, 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)	

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