* S U P D O C *

Critical Illness Claim - Doctor's Statement
Progressive Scleroderma

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. tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, 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 **Scleroderma**:

(i) Date the patient **First** consulted you for this condition (ddmmyyyy)

(ii) Details of symptom(s) presented at **First** consultation.

(iii) Date of onset of these symptoms (ddmmyyyy)

(iv) What is the underlying cause(s) of the symptoms?

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(v) Exact Diagnosis of the condition:

ICD-10 Code (if applicable):

(vi) Date of **First** diagnosis (ddmmyyyy)

(vii) Date the patient **First** became aware of the illness/condition (ddmmyyyy)

(viii) Was the diagnosis of **Scleroderma** unequivocally supported by biopsy evidence? ❒ Yes ❒ No

If "Yes", please provide the followings:

Date of biopsy test done (ddmmyyyy)	Detail of biopsy evidence to support the diagnosis

If "No", please state the clinical basis of the diagnosis of **Scleroderma**

Please attach a copy of the biopsy reports.

(ix) Was the diagnosis of **Scleroderma** unequivocally supported by serological evidence? ❒ Yes ❒ No

If "Yes", please provide the followings:

Date of serological test done (ddmmyyyy)	Type(s)/Name(s) of serological test	Detail of serological evidence to support the diagnosis

If "No", please state the clinical basis of the diagnosis of **Scleroderma**

Please attach a copy of the serological reports.

2) Name and address of the doctor who **First** diagnosed the patient of this illness/condition.

3) Please describe in detail the progression of the illness/condition since it was **First** diagnosed.

4) Please describe the extent of the illness/condition when the patient was **Last** seen at your hospital/clinic.

5) Was the heart involved in the diagnosis of **Scleroderma**? ❒ Yes ❒ No

If "Yes", please state the clinical basis of the heart involved in the diagnosis of **Scleroderma**.

6) Were the lungs involved in the diagnosis of **Scleroderma**? ❒ Yes ❒ No

If "Yes", please state clinical basis of the lungs involved in the diagnosis of **Scleroderma**.

7) Were the kidneys involved in the diagnosis of **Scleroderma**? ❒ Yes ❒ No

If "Yes", please state clinical basis of the kidneys involved in the diagnosis of **Scleroderma**.

8) Please state whether the patient is suffering from the followings:

(i) Localised scleroderma (linear scleroderma or morphea) ❒ Yes ❒ No

(iii) Eosinophilic fascitis ❒ Yes ❒ No

If "Yes" to any of the above, please state date of **First** diagnosis (ddmmyyyy):

9) Please state whether the patient is suffering from CREST Syndrome? ❒ Yes ❒ No

If "Yes", please provide the followings:

i) Was there skin with deposits of calcium (calcinosis)? ❒ Yes ❒ No

ii) Was there skin thickening of the fingers or toes (sclerodactyly)? ❒ Yes ❒ No

iii) Was there esophagus involved? ❒ Yes ❒ No

iv) Was there telangectasia (dilated capillaries)? ❒ Yes ❒ No

v) Was there Raynaud's Phenomenon causing artery spasms in the extremities? ❒ Yes ❒ No

Please state date of **First** diagnosis (ddmmyyyy):

If "No" to i) to v), please state the clinical basis of the diagnosis with CREST Syndrome.

10) Please provide details of any other **investigation** performed, with dates.

Please attach a copy of the reports.

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11) Please provide details of **treatment** prescribed, with dates (e.g. immunosuppressive therapy, anti-fibrotic agents, etc.).

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

Name of doctor and Address of hospital/clinic	Date of **First** & **Last** consulation	Reasons for consultation

3) Has the patient ever been hospitalised for Scleroderma or its related symptoms or complications? ❒ Yes ❒ No

If "Yes", please advise:

Date of hospitalisation	Reasons for hospitalisation	Treatment received (including operation, if any)	Name of doctor/surgeon & Address of hospital

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

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

5) Please describe the nature and severity of the patient's **physical** and **mental** disability and limitation, if any.

6) a) Is the patient mentally incapacitated? ❒ Yes ❒ No

b) If the patient is mentally incapacitated, is he/she mentally capable of receiving or handling money? ❒ Yes ❒ No

7) Has active treatment and therapy now been rejected in favour of relief of symptoms? ❒ Yes ❒ No
If "Yes", please provide full details why this view / course of action is taken.

8) Based on the **Last** consultation, is the condition highly likely to lead to death within the next:
(i) six (6) months? ❒ Yes ❒ No
(ii) twelve (12) months? ❒ Yes ❒ No

If "Yes" to (i) and/or (ii), please provide details on the basis of your evaluation.

9) Is the patient's diagnosis directly or indirectly, wholly or partly caused by or arising from or contributed to by:

i) Human Immunodeficiency Virus (HIV)
or Acquired Immune Deficiency Syndrome (AIDS) infection? ❒ Yes ❒ No

If "Yes", please state:
Date of Diagnosis of AIDS/HIV (dd/mm/yyyy): | | | | | | | | |

Date the patient **First** became aware of the condition (ddmmyyyy): | | | | | | | | |

ii) wilful misuse of drugs? ❒ Yes ❒ No
iii) wilful misuse of alcohol? ❒ Yes ❒ No
iv) congenital anomaly or defect? ❒ Yes ❒ No

If "Yes" for any of the above, please provide the details including diagnosis date, name of doctor and clinic who **First** diagnosed the patient with HIV or AIDS, wilful misuse of drugs, wilful misuse of alcohol or congenital anomaly or defect. Please provide copy of test result.

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

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11) Please enclose a copy of all reports including specialist or hospital reports, biopsy report, 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)	