* S U P D O C *

Singlife

Critical Illness Claim - Doctor's Statement
Special Benefit – Kawasaki Disease

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?

C) Details of Illness

1) Please provide details of **Kawasaki Disease:**

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

(ii) Details of symptom(s) presented at 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 condition: (ddmmyyyy)

2) Name and address of the doctor who **First** diagnosed the medical condition.

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3) Name and address of doctor that the patient is seeing for management of his/her medical condition.

4) Is there evidence of dilation or aneurysm formation in the coronary arteries? ❒ Yes ❒ No

If "Yes", please provide the details of the dilation or aneurysm formation in the coronary arties and attach copy of the results of all the investigations tests performed confirming this.

5) What is the date of onset and duration of the coronary artery dilation or aneurysm formation? (dd/mm/yyyy)

6) Is there evidence of cardiac involvement manifested by dilation or aneurysm formation persisted for at least six (6) months after initial acute episode? ❒ Yes ❒ No

If "Yes", please provide details and its supporting diagnostic laboratory evidence.

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 the medical condition or **any possible related illness**? ❒ Yes ❒ No

If "Yes", please give details:

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

3) Has the patient ever been hospitalised for the medical condition **o**r its related symptoms or complications? If "Yes", please advise: ❒ Yes ❒ No

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

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4) Is there anything in the patient's **personal medical history** or **family history** which would have increased the risk of the Fulminant Hepatitis / Hepatitis with Cirrhosis or its related illness? If "Yes", please give details: Exact diagnosis — Date of diagnosis — Name of doctor & address of hospital/clinic	❒ Yes ❒ No
5) Please describe the nature and severity of the patient's **physical** and **mental** disability and limitation, if any.	
6) Is the patient's condition or surgery performed in any way related or due to:	
i) AIDS, AIDS-related complex or infection by HIV?	❒ Yes ❒ No
ii) Drug abuse or use of drug not prescribed by registered medical practitioner?	❒ Yes ❒ No
iii) Alcohol abuse or misuse?	❒ Yes ❒ No
iv) Congenital anomaly or defect?	❒ Yes ❒ No
v) Attempted suicide or self-inflicted injuries?	❒ 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, AIDS, drug abuse, alcohol abuse or congenital anomaly. Please provide copy of test result.	
7) Please provide us with any other additioanl information that will enable the Company to assess this claim.	
8) Please enclose a copy of all reports including specialist or hospital reports, liver biopsy, liver/abdominal ultrasound and radiological report, endoscopy results, laboratory evidence (including serial liver function tests), 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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