* S U P D O C *

Singlife

Critical Illness Claim - Doctor's Statement
Systemic Lupus Erythematosus with Lupus Nephritis

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, diabetes, hypertension, abnormal urinalysis 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 **Systemic Lupus Erythematosus** condition.

(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?

(v) Exact Diagnosis of the condition:

ICD-10 Code (if applicable):

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

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

2) Was the diagnosis of **Systemic Lupus Erythematosus** confirmed by specialist in Rheumatology and Immunology? ❒ Yes ❒ No

If "Yes", please provide the Name and address of the specialist who **First** diagnosed the patient of **Systemic Lupus Erythematosus** condition.

3) Are the following internal organs involved due to the diagnosis of **Systemic Lupus Erythematosus**?

a) Kidneys? ❒ Yes ❒ No

b) Brain? ❒ Yes ❒ No

c) Heart or pericardium? ❒ Yes ❒ No

d) Lungs or pleura? ❒ Yes ❒ No

e) Joints as the presence of polyarticular inflammatory arthritis? ❒ Yes ❒ No

f) Skin? ❒ Yes ❒ No

If "Yes" to any of the above, please describe the nature and extent of the impairment, with date(s) (ddmmyyyy)

4) Was the patient diagnosed of discoid lupus and those forms with haematological involvement? ❒ Yes ❒ No

If "Yes", please provide details.

5) If the kidneys were affected, was renal biopsy performed? ❒ Yes ❒ No

If "Yes", please

i) Elaborate the biopsy results

ii) Date of the renal biopsy done (ddmmyyyy)

6) Is there evidence of Lupus Nephritis? ❒ Yes ❒ No

If "Yes", please advise the following:

i) Describe the symptoms

ii) Was renal biopsy performed? ❒ Yes ❒ No

If "Yes", please

a) Elaborate the biopsy results

b) Date of the renal biopsy done (ddmmyyyy)

iii) Based on the renal biopsy performed, please indicate the appropriate staging of the patient's lupus nephritis in accordance with the World Health Organization (WHO) classification:

a) **Class I** Minimal Change Lupus Glomerulonephritis ❒ Yes ❒ No

b) **Class II** Messangial Lupus Glomerulonephritis ❒ Yes ❒ No

c) **Class III** Focal Segmental Proliferative Lupus Glomerulonephritis ❒ Yes ❒ No

d) **Class IV** Diffuse Proliferative Lupus Glomerulonephritis ❒ Yes ❒ No

e) **Class V** Membranous Lupus Glomerulonephritis ❒ Yes ❒ No

iv) Based on the renal biopsy performed, please indicate the appropriate staging of the patient's lupus nephritis in accordance with the Renal Pathology Society / International Society of Nephrology (RPS/ISN) classification:

a) **Class I** Minimal mesangial lupus nephritis ❒ Yes ❒ No

b) **Class II** Mesangial proliferative lupus nephritis ❒ Yes ❒ No

c) **Class III** Focal lupus nephritis (active and chronic; proliferative and sclerosing) ❒ Yes ❒ No

d) **Class IV** Diffuse lupus nephritis (active and chronic; proliferative and sclerosing; segmental and global) ❒ Yes ❒ No

e) **Class V** *Membranous lupus nephritis* ❒ Yes ❒ No

f) **Class VI** Advanced sclerosis lupus nephritis ❒ Yes ❒ No

7) Is the patient currently on systematic lupus immunosuppressive therapy due to involvement of multiple organs? ❒ Yes ❒ No

If "Yes", please provide:

i) Date of systematic lupus immunosuppressive therapy **First** started (ddmmyyyy):

ii) Has the systematic lupus immunosuppressive therapy lasted for a period of at least 6 months? ❒ Yes ❒ No

If "No", please provide the reason.

8) Please provide details of the investigation performed, **with dates**, that confirm the diagnosis of system lupus erythematosus with lupus nephritis (e.g. Antibody tests, including ANA panel, Chest X-Ray, renal biopsy, urinalysis, laboratory tests such as RFT, CBC, rheumatoid factor and etc.)

Please attach a copy of the above investigation reports.

9) What treatment has been administered?

10) Please provide details of **current** treatment.

11) Is the patient still on follow-up at your hospital / clinic? ❒ Yes ❒ No

If "Yes", please advise date of next appointment (ddmmyyyy)

If "No", please state date of discharge (ddmmyyyy)

D) Other Information

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

2) 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 provide details

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.

3) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for the **Systemic Lupus Erythematosus** / **Lupus Nephritis 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

4) Has the patient ever been hospitalised for the **Systemic Lupus Erythematosus and/or Lupus Nephritis** 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

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5)	Is there anything in the patient's **personal medical history** or **family history** which would have increased the risk of the Systemic Lupus Erythematosus and/or Lupus Nephritis? ❒ Yes ❒ No If "Yes", please give details: Exact diagnosis / Date of diagnosis / Name of doctor & address of hospital/clinic
6)	Please describe the nature and severity of the patient's **physical** and **mental** disability and limitation, if any.
7)	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
8)	Please provide us with any other additional information that will enable the Company to assess this claim.
9)	Please enclose a copy of all reports including specialist or hospital 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)	