* S U P D O C *

Singlife

Disability Income and/or Total & Permanent Disability and/or Terminal Illness Claim - Doctor's Statement

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

A) Patient's Particulars

Name of Patient	Gender	Occupation

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, 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 Disability / Illness

1) Please provide details of current Disability/Illness:

(i) Date of **First** consultation for this current 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):

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

2) What were the mental and physical impairments presented during the **Last** consultation?

3) Please state your assessment of the patient's limb power:

Date of Assessment (ddmmyyyy)		**Limb Power**		**Limb Power**
	Left upper limb		Right upper limb	
	Left lower limb		Right lower limb	

4) Please state your assessment of the patient's power grip and precision grip:

Date of Assessment (ddmmyyyy)		**Power Grip**		**Power Grip**
	Left upper limb		Right upper limb	
	Left lower limb		Right lower limb	

Date of Assessment (ddmmyyyy)		**Precision Grip**		**Precision Grip**
	Left upper limb		Right upper limb	
	Left lower limb		Right lower limb	

5) Please provide full details and results of all **investigations** (with dates) undertaken for the diagnosis and **attach** a copy of all relevant test reports which confirmed the diagnosis.

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

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7) Is the condition a result of an **Accident**? ❒ Yes ❒ No

If 'No", please proceed to Question 8.

If "Yes", please provide details as follows:

(i) Date of Accident (ddmmyyyy) | | | | | | | | |

(ii) Time of Accident | | a.m. / p.m.

(iii) Place of Accident

(iv) Describe how the accident happened.

(v) Describe the extent and severity of the injuries/disability sustained, including exact site(s) of the body.

(vi) Was the accident reported to the police? ❒ Yes ❒ No

If "Yes", please provide the following information and **attach** a copy of the police report.

Police Division | Name of Police Officer-in-charge

(vii) Was the patient under the influence of alcohol and/or drugs at the time of accident ❒ Yes ❒ No

If "Yes", please elaborate (e.g. result of blood alcohol concentration, alcohol breath test; name of drugs, quantity consumed, etc.)

8) Please describe and elaborate on the nature and severity of the patient's **physical** disability and limitation.

9) Please describe and elaborate on the nature and severity of the patient's **mental** disability and limitation, including the degree of cognitive and/or intellectual impairment.

10) 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

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11) Please provide in detail the **treatment** prescribed with dates, including type of operation performed, rehabilitation programs (e.g. physiotherapy – number of cycles, commencement and termination date), medication, etc.

12) What is the name of the doctor(s) and hospital/clinic where the patient received and/or is receiving the abovementioned treatment?

13) What was the patient's response to the treatment?

14) Has the patient's condition improved, deteriorated or remained stationary: (Please circle as applicable)

(i) Since the disability commenced? Improved / Deteriorated / Remained stationary

(ii) Since the six (6) months prior to the **Last** consultation**?** Improved / Deteriorated / Remained stationary

15) If recovery can be reasonably expected, please describe the extent of possible recovery in the next:

(i) Three (3) to six (6) months:

(ii) Six (6) to twelve (12) months:

16) Based on **Last** consultation**,** if recovery is not reasonably expected, is the disability:

a) total and permanent such that there is neither then nor at any time thereafter any work, occupation or profession that the patient can ever sufficiently do or follow to earn or obtain any wages, compensation or profits? ❒ Yes ❒ No

b) beyond any hope of recovery? ❒ Yes ❒ No

If "Yes" to any of the above, please provide the following:

i) Start date of disability (ddmmyyy):

ii) Basis of your evaluation.

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17) Please provide us with the following:

Patient's occupation **just before** the disability	Patient's nature of job duties **just before** the disability

18) Based on **Last** consultation, has the disability prevented the patient to perform all the normal duties of **his/her usual occupation**? ❒ Yes ❒ No

If "No", when is the patient expected to return to his/her usual occupation? (ddmmyyyy)

If "Yes", please state:

(i) To what extent does the patient's disability prevent the patient from doing so?

(ii) Date that the patient cannot perform all the normal duties of his/her usual occupation (ddmmyyyy):

Please also attach a **detailed report** giving all findings relevant to the case the reasons on which you arrive at your opinion.

19) Based on **Last** consultation, has the disability prevented the patient to perform **any work, occupation or profession** that the patient can perform? ❒ Yes ❒ No

If "No", please state:

(i) What type of occupation and job duties the patient can perform?

(ii) What are the limitations?

(iii) Date that the patient is expected to return to any work, occupation or profession (ddmmyyyy):

If "Yes", please state:

(i) To what extent does the patient's disability prevent the patient from doing so?

(ii) Date that the patient cannot perform any work, occupation or profession that the patient can perform (ddmmyyyy):

Please also attach a **detailed report** giving all findings relevant to the case the reasons on which you arrive at your opinion.

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20) Based on the **Last** consultation**,** is the patient suffering from total and irrecoverable:

a) Loss of the sight of both eyes? ❒ Yes ❒ No

If "Yes", when did such disability commence? (ddmmyyyy) | | | | | | | | |

b) Loss of sight of one (1) eye and loss by severance or loss of use of one (1) limb or above the ankle or wrist? ❒ Yes ❒ No

If "Yes", when did such disability commence? (ddmmyyyy) | | | | | | | | |

c) Loss by severance or loss of use of both hands at or above the wrist? ❒ Yes ❒ No

If "Yes", when did such disability commence? (ddmmyyyy) | | | | | | | | |

d) Loss by severance or loss of use of both feet at or above the ankles? ❒ Yes ❒ No

If "Yes", when did such disability commence? (ddmmyyyy) | | | | | | | | |

e) Loss by severance or loss of use of one (1) hand at or above the wrist and one (1) foot at or above the ankle? ❒ Yes ❒ No

If "Yes", when did such disability commence? (ddmmyyyy) | | | | | | | | |

21) Is the patient confined to a home, hospital or other institution that provides constant care and medical attention? ❒ Yes ❒ No

If "Yes", please state the start date of confinement (dmmyyyy): | | | | | | | | |

Name and address where the patient is residing now:

22) 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.

23) Based on the **Last** consultation, is the condition highly likely to lead to death within the next:

(a) six (6) months? ❒ Yes ❒ No

(b) twelve (12) months? ❒ Yes ❒ No

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

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24) Is the patient's diagnosis directly or indirectly, wholly or partly caused by or arising from or contributed to by Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) infection? ❒ Yes ❒ No

If "Yes", please state:

Date of Diagnosis of AIDS/HIV (ddmmyyyy):

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

If "Yes", please provide the details including name of doctor and clinic who first diagnosed the patient with HIV or AIDS. Please provide copy of test result.

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

i) self-inflicted injury? ❒ Yes ❒ No

ii) suicide? ❒ Yes ❒ No

iii) wilful misuse of drugs? ❒ Yes ❒ No

iv) wilful misuse of alcohol? ❒ Yes ❒ No

v) 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 the above. Please provide copy of test result.

D) Additional Information

1) Based on the **Last consultation mentioned on Section B 1ii) above**, please **circle** as applicable in relation to the patient's ability to perform the Activities of Daily Living (ADLs), **whether aided or unaided** by special equipment, device and/or apparatus (and not pertaining to human aid).

Definition of ADL	Extent of Independence	Yes / No	If patient <u>always requires</u> another person's help, please state the followings:
Washing/Bathing: The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment • Always require another person's assistance throughout the entire activity	**Yes / No** **Yes / No** **Yes / No**	**(a) Reasons** _____ _____ **(b) Date of disability First occurred (ddmmyyyy)** ☐☐☐☐☐☐☐☐ **(c) For how long has he/she been continuously unable to do so?** _____

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Dressing: The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment • Always require another person's assistance throughout the entire activity	**Yes** / **No** **Yes** / **No** **Yes** / **No**	**(a) Reasons** _____ _____ **(b) Date of disability First occurred (ddmmyyyy)** ☐☐☐☐☐☐☐☐ **(c) For how long has he/she been continuously unable to do so?** _____
Transferring: The ability to move from a bed to an upright chair or wheelchair and vice versa.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment • Always require another person's assistance throughout the entire activity	**Yes** / **No** **Yes** / **No** **Yes** / **No**	**(a) Reasons** _____ _____ **(b) Date of disability First occurred (ddmmyyyy)** ☐☐☐☐☐☐☐☐ **(c) For how long has he/she been continuously unable to do so?** _____
Mobility: The ability to move indoors from room to room on level surfaces.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment • Always require another person's assistance throughout the entire activity	**Yes** / **No** **Yes** / **No** **Yes** / **No**	**(a) Reasons** _____ _____ **(b) Date of disability First occurred (ddmmyyyy)** ☐☐☐☐☐☐☐☐ **(c) For how long has he/she been continuously unable to do so?** _____
Toileting: The ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment • Always require another person's assistance throughout the entire activity	**Yes** / **No** **Yes** / **No** **Yes** / **No**	**(a) Reasons** _____ _____ **(b) Date of disability First occurred (ddmmyyyy)** ☐☐☐☐☐☐☐☐ **(c) For how long has he/she been continuously unable to do so?** _____

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Feeding: The ability to feed oneself once food has been prepared and made available.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment • Always require another person's assistance throughout the entire activity	**Yes** / **No** **Yes** / **No** **Yes** / **No**	**(a) Reasons** _____ _____ **(b) Date of disability First occurred (ddmmyyyy)** ☐☐☐☐☐☐☐☐ **(c) For how long has he/she been continuously unable to do so?** _____

2) Please indicate which are the ADLs that the patient would require the physical assistance of another person for **more than 74% of the time** throughout each said activity **even with** the use of **adaptive equipment**?

Please tick	Activities of Daily Living (ADLs)	Please tick	Activities of Daily Living (ADLs)
	Washing/Bathing		Mobility
	Dressing		Toileting
	Transferring		Feeding

3) What tests did you use to establish the patient's function for each of the ADLs mentioned above (e.g. standardised functional assessments, observation of patient performaing ADL-specific tasks etc.)?

4) If your assessment of the patient's function for each of the ADLs was taken from report(s) provided by the patient or relatives, please attach a copy of such report(s).

5) Are further investigations planned? ❒ Yes ❒ No

If "Yes", please elaborate:

If "No", please give reason(s):

6) What is your recommendation for the future with regards to the patient's case management, including any rehabilitation program, surgery?

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7) Please provide us with any other additional information that will enable the Company to assess this claim.
8) Please enclose a copy of all reports including specialist/physiotherapist/hospital/police reports, x-rays, CT scans, laboratory test results, inpatient discharge summary 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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