



## Critical Illness Claim - Doctor's Statement Viral Encephalitis

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

<b>A) Patient's Particulars</b>															
Name of Patient						Gender									
NRIC/FIN or Passport No.						Date of Birth (ddmmyyyy)									
						<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> </tr> </table>									
<b>B) Patient's Medical Records</b>															
1) Please state over what period does the Hospital/Clinic's record extend?															
(i) Date of first consultation (ddmmyyyy)						<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> </tr> </table>									
(ii) Date of last consultation (ddmmyyyy)						<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> </tr> </table>									
(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? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>															
If "Yes", since when? (ddmmyyyy)						<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> </tr> </table>									
If "No", please provide name and address of the patient's regular doctor.															
3) Was the patient referred to you? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>															
If "Yes", please provide:															
(i) Date referred (ddmmyyyy)						<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> </tr> </table>									
(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? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>															
(i) Date referred (ddmmyyyy)						<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> </tr> </table>									
(ii) Reason for referral:															
(iii) Name and address of doctor referred to:															

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 **Viral Encephalitis**:

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

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(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 <b>First</b> diagnosis (ddmmyyyy)	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>								
(vi) Date the patient <b>First</b> became aware of the illness/condition (ddmmyyyy)	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>								
2) Is the Encephalitis caused by viral infection? If "No", please state the underlying cause of the condition.	<input type="checkbox"/> Yes <input type="checkbox"/> No								
3) Is there severe inflammation of the brain substance (cerebral hemisphere, brainstem or cerebellum)?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
4) Please describe in full details (with dates) the extent of neurological deficits.									
5) Do the neurological deficits (described in Question 4) last for a <b>continuous</b> period of at least six (6) weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
6) Are the neurological deficits/damages irreversible and permanent? (i) If "Yes", please elaborate with supporting evidence.	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(ii) If "No", please state date of recovery <i>or</i> date for which the patient is likely to recover from these neurological deficits:	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>								
7) Please provide details of <b>investigation</b> performed, with dates (e.g. Brain MRI, culture of cerebrospinal fluid (CSF), electroencephalogram). Also, please <b>attach</b> a copy of all the relevant test reports.									

8) Name and address of the **neurologist** who **First** diagnosed the patient with Encephalitis.

9) Please provide details of current **treatment**, including any physical and speech therapy, if any.

10) Is the Encephalitis caused by HIV infection?  Yes  No  
If "Yes", please provide details including date of diagnosis of HIV infection, name and address of doctor who made the 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 Encephalitis? If "Yes", please give details:  Yes  No

<u>Exact diagnosis</u>	<u>Date of diagnosis</u>	<u>Name of doctor &amp; address of hospital/clinic</u>
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3) Please describe and elaborate on the nature and severity of the patient's **physical** and **mental** disability and limitation (e.g. loss of memory, muscle control, speech, vision, etc.).

4) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for <b>Encephalitis or any possible related illness</b> , especially any consultations concerning neurological symptoms or complaints? If "Yes", please give details:	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<table style="width: 100%; border: none;"> <tr> <td style="border: none;"><u>Name of doctor and Address of hospital/clinic</u></td> <td style="border: none;"><u>Date of first &amp; last consultation</u></td> <td style="border: none;"><u>Reasons for consultation</u></td> </tr> </table>	<u>Name of doctor and Address of hospital/clinic</u>	<u>Date of first &amp; last consultation</u>	<u>Reasons for consultation</u>		
<u>Name of doctor and Address of hospital/clinic</u>	<u>Date of first &amp; last consultation</u>	<u>Reasons for consultation</u>			
5) Has the patient ever been hospitalised for Encephalitis or its related symptoms or complications?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
If "Yes", please advise:					
<table style="width: 100%; border: none;"> <tr> <td style="border: none;"><u>Date of hospitalisation</u></td> <td style="border: none;"><u>Reasons for hospitalisation</u></td> <td style="border: none;"><u>Treatment received (including operation, if any)</u></td> <td style="border: none;"><u>Name of doctor/surgeon &amp; Address of hospital</u></td> </tr> </table>	<u>Date of hospitalisation</u>	<u>Reasons for hospitalisation</u>	<u>Treatment received (including operation, if any)</u>	<u>Name of doctor/surgeon &amp; Address of hospital</u>	
<u>Date of hospitalisation</u>	<u>Reasons for hospitalisation</u>	<u>Treatment received (including operation, if any)</u>	<u>Name of doctor/surgeon &amp; Address of hospital</u>		
6) Please provide us with any other additional information that will enable the Company to assess this claim.					
7) Please enclose a copy of all reports including specialist or hospital reports, cerebrospinal fluid analysis result, laboratory evidence, computed tomography, 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 & Official Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	