



**Critical Illness Claim - Doctor's Statement
Special Benefit - Diabetic Complications / Insulin Dependent Diabetes Mellitus**

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) <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>								
B) Patient's Medical Records									
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; 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>								
(ii) Date of Last consultation (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>								
(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? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If "Yes", since when? (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>								
If "No", please provide name and address of the patient's regular doctor.									
3) Was the patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If "Yes", please provide:									
(i) Date referred (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>								
(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? <input type="checkbox"/> Yes <input type="checkbox"/> No									
(i) Date referred (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>								
(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:

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

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

(iii) Date of onset of these symptoms (ddmmyyy):

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(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 (ddmmyyy):

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(vii) Date the patient First became aware of the condition (ddmmyyy)									
2) Name and address of the doctor who First diagnosed the medical condition.									
3) Name and address of doctor that the patient is seeing for management of his/her diabetes.									
4) Please provide details of recent blood sugar levels and date of assessment (dd/mm/yyyy).									
5) Is there evidence of Diabetic Retinopathy?								<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes", please provide the following details:									
(i) Please circle which of the eye is affected by diabetic retinopathy?	Left Eye	Right Eye							
(ii) Using the Snellen eye chart, what is the best possible corrected visual acuity of both eyes? Date of test (ddmmyyy)	Left Eye	Right Eye							
(iii) Does the patient require laser treatment for his/her diabetic retinopathy?								<input type="checkbox"/> Yes <input type="checkbox"/> No	
(iv) If laser treatment had been given, please state the date of such treatment (ddmmyyy).									
(v) Is such treatment absolutely necessary? If "No", please specify what alternative treatment is available for the patient's condition.								<input type="checkbox"/> Yes <input type="checkbox"/> No	
(vi) Please provide results of investigations done and attach copies of the fluorescent fundus angiography report.									
6) Is there evidence of Diabetic Nephropathy?								<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes", please provide the following details:									
(i) Is there decreased renal function of less than eGFR less than 30 ml/min/1.73m ² ? Please provide the eGFR readings, including dates of assessment.								<input type="checkbox"/> Yes <input type="checkbox"/> No	

(ii) Is there ongoing proteinuria greater than 300 mg/24 hours? Please provide the proteinuria readings, including dates of assessment.	<input type="checkbox"/> Yes <input type="checkbox"/> No										
(iii) Please provide the results of investigations done and attach copies of renal function test and urinalysis reports.											
7) Has the patient undergone any amputation due to diabetes? If "Yes", please provide the following details:	<input type="checkbox"/> Yes <input type="checkbox"/> No										
(i) The underlying cause for the amputation.											
(ii) The site/area of amputation is:											
a) Foot	<input type="checkbox"/> Yes <input type="checkbox"/> No										
b) Toe	<input type="checkbox"/> Yes <input type="checkbox"/> No										
c) Hand	<input type="checkbox"/> Yes <input type="checkbox"/> No										
d) Finger	<input type="checkbox"/> Yes <input type="checkbox"/> No										
e) Others If "Yes" under Others, please state the specific site/area:	<input type="checkbox"/> Yes <input type="checkbox"/> No										
(iii) The name and type of surgery patient has undergone.											
(iv) Exact date of surgery (ddmmyyyy)	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>										
(v) The name and address of hospital where the surgery was performed and provide copy of operation report.											
8) Is there evidence of Insulin Dependent Diabetes Mellitus?											
<input type="checkbox"/> Yes <input type="checkbox"/> No											
If "Yes", please provide the following details:											
(i) Does the patient require continuous dependence on exogenous insulin for the preservation of life?	<input type="checkbox"/> Yes <input type="checkbox"/> No										
(ii) Has the Insulin Dependent Diabetes Mellitus persisted for at least 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No										
If "Yes", please provide date of commencement (ddmmyyyy):											
<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>											

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 ? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please give details:									
<u>Name of doctor and Address of hospital/clinic</u>	<u>Date of First & Last consultation</u>								
<u>Reasons for consultation</u>									
3) Has the patient ever been hospitalised for the medical condition or its related symptoms or complications? If "Yes", please advise: <input type="checkbox"/> Yes <input type="checkbox"/> No									
<u>Date of hospitalisation</u>	<u>Reasons for hospitalisation</u>								
<u>Treatment received (including operation, if any)</u>	<u>Name of doctor/surgeon & Address of hospital</u>								
4) Is there anything in the patient's personal medical history or family history which would have increased the risk of the Diabetic Complications or Insulin Dependent Diabetes Mellitus? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please give details:									
<u>Exact diagnosis</u>	<u>Date of diagnosis</u>								
<u>Name of doctor & address of hospital/clinic</u>									
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? <input type="checkbox"/> Yes <input type="checkbox"/> No									
b) If the patient is mentally incapacitated, is he/she mentally capable of receiving or handling money? <input type="checkbox"/> Yes <input type="checkbox"/> No									
7) 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? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If "Yes", please provide details:									
Date of Diagnosis of AIDS/HIV (ddmmyyyy):	<table border="1" style="width: 100%; height: 20px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>								
Date the patient First became aware of the condition: (ddmmyyyy):	<table border="1" style="width: 100%; height: 20px;"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>								

- 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, AIDS, drug abuse, alcohol abuse or congenital anomaly. Please provide copy of test result.

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, fluorescent fundus angiography, oral glucose tolerance test results, blood test results, eGFR readings results, proteinuria readings results, histology report, ultrasound and radiological 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 & Official Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	