* S U P D O C *

Singlife

Critical Illness Claim - Doctor's Statement
End Stage Liver Failure / Liver Surgery / Liver Cirrhosis

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?

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 **End Stage Liver Failure/ Liver Cirrhosis/ Liver problem**:
(*please **circle** the appropriate condition):*

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

(i) Details of symptom(s) presented at first consultation, and date these symptoms First started.

(ii) What is the underlying cause(s) of the symptoms?

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(iii) Exact Diagnosis of the condition:

ICD-10 Code (if applicable):

(iv) Date of **First** diagnosis (ddmmyyyy) | | | | | | | | |

(v) Date the patient **First** became aware of a general deterioration in condition: (ddmmyyyy) | | | | | | | | |

2) Name and address of the doctor who first diagnosed the patient of this illness/condition.

3) Is the patient diagnosed of end stage liver failure? ❒ Yes ❒ No

If "Yes", please state date of First diagnosis (ddmmyyyy) | | | | | | | | |

4) (i) How long has the patient been jaundiced?

(ii) Would the jaundice be permanent? ❒ Yes ❒ No

5) Is there evidence of ascites? ❒ Yes ❒ No

If "Yes", please state:

(i) Date of first detection (ddmmyyyy) | | | | | | | | |

(ii) Mode of detection (e.g. clinical, paracentesis, ultrasound):

6) Is there evidence of hepatic encephalopathy? ❒ Yes ❒ No

If "Yes", please provide details including dates, underlying causes, complications (if any) and treatment.

7) Was there partial hepatectomy of at least one entire lob of the liver? ❒ Yes ❒ No

If "Yes", please advise:

(i) Date of surgery (ddmmyyyy) | | | | | | | | |

(ii) Reason(s) for requiring hepatectomy:

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(iii) Was partial hepatectomy absolutely necessary? ❒ Yes ❒ No

If "Yes", please support with evidence.

8) Is there evidence of liver cirrhosis? ❒ Yes ❒ No

If "Yes", please advise:

(i) HAI-Knodell score with a copy of the liver biopsy report.

(ii) Name of Hepatologist and address of hospital who gave the liver cirrhosis diagnosis.

9) Was the liver disease suffered by the patient secondary to:

(i) Alcohol abuse? ❒ Yes ❒ No

(ii) Drug abuse? ❒ Yes ❒ No

10) Was there evidence of bleeding from the oesophageal varices? ❒ Yes ❒ No

If "Yes", please state:

(i) Episodes of bleeding, including date and treatment.

(ii) Was there endoscopy and/or radiological evidence of oesophageal varices? ❒ Yes ❒ No

If "Yes", please attach a copy of the report.

11) Please provide details of **investigation** performed, with dates, including a serial of liver function test results with Gamma GT and Bilirubin levels.

Please **attach** a copy of the biopsy and serology reports, paracentesis and ultrasound reports.

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

13) 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) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for the **Chronic Liver Disease or any possible related illness**? If "Yes", please give details: ❒ Yes ❒ No

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

3) Has the patient ever been hospitalised for the **Chronic Liver Disease o**r its related symptoms of 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

4) Is there anything in the patient's **personal medical history** or **family history** which would have increased the risk of the Chronic Liver Disease? If "Yes", please give details: ❒ Yes ❒ No

Exact diagnosis	Date of diagnosis	Name of doctor & address of hospital/clinic

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5) Please describe the nature and severity of the patient's **physical** and **mental** disability and limitation, if any.
6) 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.
7) Can you confirm that the advent of death is highly probable within: (i) six (6) months? ❒ Yes ❒ No (ii) twelve (12) months? ❒ Yes ❒ No If "Yes", please describe and provide relevant medical reports that support this view.
8) Please provide us with any other additioanl information that will enable the Company to assess this claim.
10) Please enclose a copy of all reports including specialist or hospital reports, biopsy 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 & Offical Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	

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