Living Benefit Claim - Doctor's Statement
Hospital Care Benefits for Child

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/BC/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, any illness or any congenital condition? If "Yes", please provide: ❒ Yes ❒ No

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?

C) Details of Illness

1) Please **tick (√)** the box the condition to which this doctor's report relates:

❒ Admission into neonatal intensive care unit (NICU) or high dependency unit (HDU)

❒ Hospitalisation due to Hand, Foot and Mouth Disease

❒ Incubation of the newborn child for more than 3 consecutive days immediately following birth

❒ Phototherapy or Blood Transfusion for severe neonatal jaundice

❒ Premature birth requiring neo-natal ICU/HDU

2) Please provide details of the condition.

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

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

(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 this condition (ddmmyyyy)

3) Was the child born prematurely? If "Yes", please provide the details. ❒ Yes ❒ No

(i) Gestation period ______ weeks (ii) Birth weight ______ grams

4) Was the child incubated for more than 3 consecutive days immediately following birth? ❒ Yes ❒ No

If "Yes", please state the period of incubation (ddmmyyyy)

From ________ to ________

5) Was the child admitted to a neonatal intensive care unit (NICU)? ❒ Yes ❒ No

If "Yes", please state the period of confinement (ddmmyyyy)

From ________ to ________

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6) Was the child admitted to a high dependency unit (HDU)? ❒ Yes ❒ No

If "Yes", please state the period of confinement (ddmmyyyy)

From | | | | | | | | | to | | | | | | | | |

7) Did the child requires hospitalisation for at least 3 consecutive days for treatment with phototherapy or blood transfusion within 30 days after birth? If "Yes", please confirm the following: ❒ Yes ❒ No

(i) Was there presence of neonatal jaundice? ❒ Yes ❒ No

If "Yes", please state the **total serum bilirubin level**:

(ii) For term infant, at or greater than 37 weeks gestational age:

(a) 25 to 72 hours after birth: ____ μ mol/L (micromol/litre)

(b) More than 72 hours after birth: ____ μ mol/L (micromol/litre)

(c) Please provide copy of diagnostic and blood test results.

(ii) For pre-matured infants, at less than 37 weeks gestational age:

(a) 25 to 72 hours after birth: ____ μ mol/L (micromol/litre)

(b) More than 72 hours after birth: ____ μ mol/L (micromol/litre)

(c) Please provide copy of diagnostic and blood test results.

8) Was the child hospitalised for **Hand, foot and mouth (HFM) disease**? ❒ Yes ❒ No

If "No", please proceed to **question 9**.

If "Yes", please state:

(i) Date of admission (ddmmyyyy)

| | | | | | | | |

(ii) **Provisional diagnosis** on admission.

(iii) Were there any viral studies done to confirm the diagnosis of HFM Disease? ❒ Yes ❒ No

If "Yes", please indicate the investigations carried out and their results.

(iv) Did the patient suffer from any form of viral encephalitis or myocarditis during this admission? ❒ Yes ❒ No

If "Yes", please provide documented evidence of the presence of the encephalitis or myocarditis.

(v) Was positive isolation of the causative virus carried out during this admission? ❒ Yes ❒ No

(vi) Was Coxsackie A17 or Entenovirus 71 specifically isolated during the viral studies? ❒ Yes ❒ No

(vii) Did the patient suffer any neurological deficit after the date of diagnosis of the HFM Disease? ❒ Yes ❒ No

If "Yes", please state:

(a) Neurological deficits suffered.

(b) Was there evidence of neurological deficit that lasted at least 30 days after the date of diagnosis of the HFM Disease was established? Please elaborate. ❒ Yes ❒ No

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9) What is the underlying cause(s) of the condition?	
10) Was this pregnancy conceived through any of the following fertility treatments: (a) Vitro Fertilization (**IVF**) ❐ Yes ❐ No (b) Intra-Cytoplasmic Sperm (**ICSI**) ❐ Yes ❐ No (c) Intrauterine Insemination (**IUI**) ❐ Yes ❐ No (d) Intracervical Insemination (**ICI**) ❐ Yes ❐ No (e) If none of the above, please specify the fertility treatment that the patient has received:	
11) Was the patient's mother carrying 5 or more babies in this pregnancy? If "No", please state the **number** of babies that the patient has carried in this single pregnancy.	❐ Yes ❐ No
12) Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? If "Yes", please provide the date of HIV/AIDS diagnosis. (dd/mm/yyyy)	❐ Yes ❐ No
11) Is the diagnosis related to self-inflicted injury, suicide or attempted suicide?	❐ Yes ❐ No
12) Is the diagnosis related to any deliberate misuse of any drugs or alcohol?	❐ Yes ❐ No
13) Is the diagnosis related to the use of unprescribed drugs where such drugs are required by the law to be prescribed by a registered medical doctor?	❐ Yes ❐ No
14) Please enclose a copy of all reports including specialist or hospital reports, laboratory evidence, surgical report, etc.	

D) 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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