



**Living Benefit Claim - Doctor's Statement
Pregnancy Complications Benefit – Disseminated Intravascular Coagulation**

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, diabetes, hypertension, hyperlipidaemia, anaemia etc.)? If "Yes", please provide:	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<table style="width: 100%; border: none;"> <tr> <td style="border: none;"><u>Details of symptoms</u></td> <td style="border: none;"><u>Exact diagnosis</u></td> <td style="border: none;"><u>Date diagnosed</u></td> <td style="border: none;"><u>Treatment</u></td> </tr> </table>	<u>Details of symptoms</u>	<u>Exact diagnosis</u>	<u>Date diagnosed</u>	<u>Treatment</u>	
<u>Details of symptoms</u>	<u>Exact diagnosis</u>	<u>Date diagnosed</u>	<u>Treatment</u>		
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:					
<u>No. of years of smoking</u>	<u>No. of sticks per day</u>	<u>Source of information</u>			
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.					
<u>Type of alcohol</u>	<u>Quantity per Consumption</u>	<u>Frequency (per week / month, etc.)</u>	<u>Source of information</u>		

C) Details of Illness

1) Please provide details of Disseminated Intravascular Coagulation ("DIC") Condition.											
(i) Date the patient First consulted you for this condition (ddmmyyy)	<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>										
(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 (ddmmyyy)	<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) Date the patient First became aware of this condition (ddmmyyy)	<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>										

2) Did DIC occur as a result of pregnancy? If "No", please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No								
3) Did DIC occur within the first 7 months of pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
4) Please state if the following were present:									
(a) Over activation of the coagulation and fibronolytic system	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(b) Microvascular thrombosis	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(c) Consumption of platelets and coagulation factors	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(d) Major haemorrhage	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(e) Treatment with frozen plasma and platelet concentrates	<input type="checkbox"/> Yes <input type="checkbox"/> No								
Please provide copy of the investigation results to support the diagnosis.									
5) What is the underlying cause(s) of the DIC?									
6) Was this pregnancy conceived through any of the following fertility treatments:									
(a) Vitro Fertilization (IVF)	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(b) Intra-Cytoplasmic Sperm (ICSI)	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(c) Intrauterine Insemination (IUI)	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(d) Intracervical Insemination (ICI)	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(e) If none of the above, please specify the fertility treatment that the patient has received:									
7) Was the patient carrying 5 or more babies in this pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
If "No", please state the number of babies that the patient has carried in this single pregnancy.									
8) Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
If "Yes", please provide the date of HIV/AIDS diagnosis (dd/mm/yyyy)	<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>								
9) Is the diagnosis related to self-inflicted injury, suicide or attempted suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
10) Is the diagnosis related to any deliberate misuse of any drugs or alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
11) 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
12) 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 & Official Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	