



Critical Illness Claim – Doctor’s Statement
Coronary Artery By-Pass Surgery or Other Serious Coronary Artery Disease

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

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|--|---|--|--|--|--|--|--|--|--|
| 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> | | | | | | | | |
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| 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> | | | | | | | | |
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| (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> | | | | | | | | |
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| 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> | | | | | | | | |
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| (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, overweight, hypertension, hyperlipidaemia, diabetes, hepatitis, etc.)? If "Yes", please provide: | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| <table style="width: 100%; border: none;"> <tr> <td style="width: 25%; border-bottom: 1px solid black;"><u>Details of symptoms</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Exact diagnosis</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Date diagnosed</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><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> | | |

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|--|--|--|--|--|--|--|--|--|--|--|--|
| C) Details of Illness | | | | | | | | | | | |
| 1) Please provide details of the heart disease leading to Surgery or Serious Coronary Artery Disease : | | | | | | | | | | | |
| (i) Date of first consultation for this 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> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table> | | | | | | | | | | |
| | | | | | | | | | | | |
| (ii) Details of symptom(s) presented during the 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 First 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> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table> | | | | | | | | | | |
| | | | | | | | | | | | |
| (vi) Date the patient first 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> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table> | | | | | | | | | | |
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2) Name and address of the **cardiologist** who **First** diagnosed the patient with this condition.

3) Please tick (✓) the type of surgery performed:

Coronary Artery Bypass Surgery
 "Keyhole" Surgery
 Enhanced External Counterpulsation

Transmyocardial Laser Revascularization
 Atherectomy
 Angioplasty

Others (please specify):

4) Date the surgery was performed (ddmmyyyy)

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5) Please specify the coronary arteries involved and the degree (%) of narrowing, and **attach** a copy of **Angiogram report**.

| Coronary Artery | Stenosis | Percentage of Stenosis |
|---------------------------------|--|------------------------|
| Left Main Stem | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Left Anterior Descending Artery | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Left Circumflex Artery | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Right Coronary Artery | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

6) If an open chest (open heart) surgery was performed, please state:

(i) Number of grafts:

(ii) Sites of grafts inserted:

7) Name of surgeon(s) who performed the surgery and name of hospital in which surgery was performed.

8) Please provide full details of any other treatment provided.

9) Was the above surgery considered medically necessary by the consultant cardiologist? Yes No

10) Has the patient undergone a similar surgery before? Yes No

If "Yes", please provide details, including date and place of surgery, and the reasons for the surgery.

| | |
|--|--|
| 11) Did the patient previously suffer from coronary artery disease or any related illness? If "Yes", please provide details including date of diagnosis and treatment prescribed. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12) Have any other investigative tests or procedure been performed? If "Yes", please provide details and attach a copy of the results (e.g. cardiac catheterization report, myocardial perfusion test, etc.). | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| | | | |
|--|--|--|------------------------------|
| 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 Coronary Artery Disease (e.g. obesity, hypertension, hyperlipidaemia, diabetes, angina or other cardiovascular disease, etc.)? If "Yes", please give details: | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| <u>Exact diagnosis</u> | <u>Date of diagnosis</u> | <u>Name of doctor & Address of hospital/clinic</u> | |
| | | | |
| 3) Is there anything in the patient's family history which would have increased the risk of Coronary Artery Disease? If "Yes", please give details: | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| <u>Relationship with patient</u> | <u>Nature of condition</u> | <u>Age of onset</u> | <u>Source of information</u> |
| | | | |
| 4) Please describe and elaborate on the nature and severity of the patient's disability and limitation, if any. | | | |
| | | | |
| 5) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for Coronary Artery Disease or any other related diseases? If "Yes", please give details: | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| <u>Name of doctor and Address of hospital/clinic</u> | <u>Date first & last Consulted</u> | <u>Reasons for consultation</u> | |

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|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 6) Is the patient still on follow-up? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | |
| If "Yes", please state date of next appointment (ddmmyyyy) | <table border="1" style="border-collapse: collapse; width: 100%;"> <tr><td style="width: 12.5%; height: 20px;"></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> <tr><td style="height: 20px;"></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </table> | | | | | | | | | | | | | | | | |
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| If "No", please state date of discharge (ddmmyyyy) | <table border="1" style="border-collapse: collapse; width: 100%;"> <tr><td style="width: 12.5%; height: 20px;"></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> <tr><td style="height: 20px;"></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </table> | | | | | | | | | | | | | | | | |
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| 7) Please provide us with any other additional information that will enable the Company to assess this claim. | | | | | | | | | | | | | | | | | |
| 8) Please enclose a copy of all reports including specialist or hospital reports (e.g. exercise stress tests, cardiac enzyme assays, coronary angiography, echocardiography, surgical reports, X-rays, CT scans, myocardial perfusion scans, and any other imaging studies, laboratory evidence, etc.) that are available. | | | | | | | | | | | | | | | | | |

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| 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) | |