



**Critical Illness Claim - Doctor's Statement**  
**Major Cancers / Carcinoma in-situ / Early Cancer**

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

<b>A) Patient's Particulars</b>							
Name of Patient							Gender
NRIC/FIN or Passport No.						Date of Birth (ddmmyyyy)	
<b>B) Patient's Medical Records</b>							
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? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>							
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? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>							
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? <span style="float:right"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>							
(i) Date referred (ddmmyyyy)							
(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. cyst, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, anaemia, etc.) If "Yes", please provide: <u>Details of symptoms</u> <u>Exact diagnosis</u> <u>Date diagnosed</u> <u>Treatment</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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 <b>smoking</b> , 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 <b>alcohol consumption</b> , 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 <b>Cancer</b> :											
(i) Date the patient First consulted you 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 at 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 1 <sup>st</sup> became aware of the 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>										

2) Please provide dates and details of investigation performed for the diagnosis and **attach** a copy of all relevant test reports which confirmed the diagnosis.

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3) Name and address of the doctor who **First** diagnosed the patient with this condition.

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4) What is the primary and exact site of the tumour?

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5) What is the staging of the tumour?

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6) Please state the tumour classification (e.g. TNM classification, etc.).

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7) Please confirm:

(i) Was the disease completely localized?  Yes  No

(ii) Was there invasion of adjacent tissues?  Yes  No

(iii) Were regional lymph nodes involved?  Yes  No

(iv) Were there distant metastases?  Yes  No

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8) Did the patient undergo any surgery? If "Yes", please state:  Yes  No

a) Date of surgery (ddmmyyyy)

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b) Nature of the surgery performed (e.g. mastectomy, hysterectomy, prostatectomy, gastrectomy, etc.)

c) Specify if there was full or partial resection (if applicable).

d) Reason(s) for performing the surgery.

e) Please provide copy of operation report and histology report.

<p>9) Did the patient undergo any other mode of treatment? (e.g. chemotherapy, radiotherapy, etc.). <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>          If "Yes", please provide the following details.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Date of Treatment (ddmmyyyy)</th> <th style="text-align: left; border-bottom: 1px solid black;">Type of Treatment</th> <th style="text-align: left; border-bottom: 1px solid black;">Duration of Treatment</th> <th style="text-align: left; border-bottom: 1px solid black;">Patient's Response to the Treatment</th> </tr> </thead> <tbody> <tr> <td style="height: 100px;"></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Date of Treatment (ddmmyyyy)	Type of Treatment	Duration of Treatment	Patient's Response to the Treatment				
Date of Treatment (ddmmyyyy)	Type of Treatment	Duration of Treatment	Patient's Response to the Treatment					
<p>10) Is the diagnosis Malignant Melanoma? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>          If "Yes", please provide full details of size, thickness (Breslow classification) and/or depth of invasion (Clark level)?</p>								
<p>11) Is the diagnosis Gastro-Intestinal Stromal tumour (GIST)? If "Yes", please state: <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>          (a) Tumour classification (TNM classification):          (b) Mitotic count (in HPFs):</p>								
<p>12) Is the diagnosis Leukaemia? If "Yes", please state: <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>          (a) Type of leukaemia:          (b) RAI Staging</p>								
<p>13) What is the prognosis of the patient's condition?</p>								

**D) Other Information**

<p>1) Was the tumour or cancer in any way related or in the presence of any Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) infection? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>          If "Yes", please state date HIV/AIDS was diagnosed. (ddmmyyyy)</p>	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> <td style="width: 25px;"></td> </tr> </table>										
<p>2) Was the tumour or cancer in any way caused directly or indirectly by alcohol or drug abuse? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>          If "Yes", please provide details.</p>											
<p>3) Is there anything in the patient's <b>personal medical history</b> which would have increased the risk of Cancer? If "Yes", please give details: <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; border-bottom: 1px solid black;"><u>Exact diagnosis</u></td> <td style="width: 30%; border-bottom: 1px solid black;"><u>Date of diagnosis</u></td> <td style="width: 40%; border-bottom: 1px solid black;"><u>Name of doctor &amp; address of hospital/clinic</u></td> </tr> </table>	<u>Exact diagnosis</u>	<u>Date of diagnosis</u>	<u>Name of doctor &amp; address of hospital/clinic</u>								
<u>Exact diagnosis</u>	<u>Date of diagnosis</u>	<u>Name of doctor &amp; address of hospital/clinic</u>									

4)	Is there anything in the patient's <b>family history</b> which would have increased the risk of Cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please give details:		
	<u>Relationship with patient</u> <u>Nature of condition</u> <u>Age of onset</u> <u>Source of information</u>		
5)	Has active treatment and therapy now been rejected in favour of relief of symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide full details why this view / course of action is taken.		
6)	Can you confirm that the advent of death is highly probable within: (i) six (6) months? <input type="checkbox"/> Yes <input type="checkbox"/> No (ii) twelve (12) months? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please describe and provide relevant medical reports that support this view.		
7)	Please describe and elaborate on the nature and severity of the patient's disability and limitation, if any.		
8)	Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for Cancer 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 of first &amp; last consultation</u> <u>Reasons for consultation</u>		
9)	Please enclose a copy of all reports including specialist or hospital reports, biopsy reports, cytology reports, histology reports, x-rays, CT scans, other imaging studies, 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)	