* S U P D O C *

AVIVA

# Critical Illness Claim - Doctor's Statement
# Multiple Sclerosis

**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. cyst, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, frequent falls, etc.) 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?

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 **Multiple Sclerosis**:

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

(iv) Exact Diagnosis of the condition:

ICD-10 Code (if applicable):



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| | |
|---|---|
| (v) Date of **First** diagnosis (ddmmyyyy) | |
| (vi) Date the patient **First** became aware of the illness/condition (ddmmyyyy) | |

2) Please provide details of **investigation** performed (with dates) to establish the unequivocal diagnosis of **Multiple Sclerosis** (e.g. magnetic resonance imaging, evoked potentials, cerebrospinal fluid analysis, etc.). Also, please **attach** a copy of all the relevant test reports.

3) Name and address of the doctor who **First** diagnosed the patient with Multiple Sclerosis.

4) Please describe in full details (with dates) the extent of neurological deficits.

5) Based on your records, the multiple neurological deficits (described in Question 4) have occurred over a **continuous** period of at least _____ months. Please support with evidence.

6) Is there a well-documented history of exacerbations and remissions of the said symptoms or neurological deficits? If "Yes", please elaborate with dates. ❒ Yes ❒ No



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7) Are the neurological deficits/damage due to:

(i) Systemic Lupus Erythematosus ("SLE") ❒ Yes ❒ No

(ii) Human Immunodeficiency Virus ("HIV") ❒ Yes ❒ No

(iii) Others (please specify):

8) Please provide details of current **treatment**, including name and dosage of medication, operation contemplated (if any).

10) Has the patient ever been hospitalised for Multiple Sclerosis or its related symptoms or complications? ❒ Yes ❒ No

If "Yes", please advise:

| Date of hospitalisation | Reasons for hospitalisation | Treatment received (including operation, if any) | Name of doctor/surgeon & Address of hospital |
|---|---|---|---|

**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 Multiple Sclerosis? If "Yes", please give details: ❒ Yes ❒ No

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



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3) Is there anything in the patient's **family history** which would have increased the risk of Multiple Sclerosis? If "Yes", please give details: ❒ Yes ❒ No

| Relationship with patient | Nature of condition | Age of onset | Source of information |
|---|---|---|---|

4) 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.

5) 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.

6) Please describe and elaborate on the nature and severity of the patient's **physical** disability and limitation, if any.

7) Please describe and elaborate on the nature and severity of the patient's **mental** disability and limitations, including the degree of cognitive and/or intellectual impairment.



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8) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for **Multiple Sclerosis or any possible related illness**, especially any consultations concerning neruological symptoms or complaints, however minor in nature? ❒ Yes ❒ No
If "Yes", please give details:

| Name of doctor and Address of hospital/clinic | Date of first & last consulation | Reasons for consultation |
|---|---|---|
| | | |

9) 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, magnetic resonance imaging, evoked potentials result, cerebrospinal fluid analysis result, 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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