* S U P D O C *

Singlife

# Critical Illness Claim - Doctor's Statement
# Parkinson's Disease

**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. tumour, stroke, diabetes, hypertension, hyperlipidaemia, hepatitis, obesity, etc.) ❒ Yes ❒ No

If "Yes", please provide:

| 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 |
|---|---|---|---|
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**C) Details of Illness**

1) Please provide details of the **Parkinson's Disease**:

(i) Date of **First** consultation for this condition (ddmmyyyy)

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(ii) Details of symptom(s) presented during the **First** consultation

(iii) Date of onset of these symptoms (ddmmyyyy)

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

(v) Exact Diagnosis of the condition:

ICD-10 Code (if applicable):



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(vi) Date of **First** Diagnosis (ddmmyyyy)

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|---|---|---|---|---|---|---|---|
| | | | | | | | |

(vii) Date the patient **First** became aware of the illness/condition (ddmmyyyy)

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

3) Name and address of the **Neurologist** who **First** diagnosed the patient with Parkinson's Disease.

4) Please describe in details the extent of neurological deficits suffered by the patient (with dates).

5) Please advise if the Parkinson's Disease is:

(i) Idiopathic in nature ❒ Yes ❒ No

(ii) Toxin-caused ❒ Yes ❒ No

(iii) Drug-induced (e.g. resulted from treatment for any other illness, etc.) ❒ Yes ❒ No

(iv) Associated with any other disease (e.g. Wilson's disease or Huntington's Chorea) ❒ Yes ❒ No

If "Yes" to any of the above, please elaborate including date of diagnosis, name and address of the **Neurologist** who made the diagnosis and source of information.

6) Please provide details of current **treatment** received for Parkinson's disease, including the name and dosage of medication, operation contemplated (if any)?

7) Can the condition be controlled with medication? ❒ Yes ❒ No

If "Yes", please state date the medical treatment **First** started (ddmmyyyy)

| | | | | | | | |
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8) Are there signs of progressive impairment? ❒ Yes ❒ No

If "Yes", please elaborate (with dates) on how the condition has deteriorated over time.

**D) Additional Information**

1) Based on the **Last consultation mentioned on Section B 1ii) above**, please **circle as applicable** in relation to the patient's ability to perform the Activities of Daily Living (ADLs), whether aided or unaided by special equipment, device and/or apparatus (and not pertaining to human aid).

| Definition of ADL | Extent of Independence | Yes / No | If patient <u>always requires</u> another person's help, please state the followings: |
|---|---|---|---|
| **Washing/Bathing:** The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means. | • Able to perform independently and without any assistance.<br>• Able to perform with aid of special equipment<br>• Always require another person's assistance throughout the entire activity | **Yes / No**<br>**Yes / No**<br>**Yes / No** | **(a) Reasons**<br>_____<br>_____<br>**(b) Date of disability First occurred (ddmmyyyy)**<br>☐☐☐☐☐☐☐☐<br>**(c) For how long has he/she been continuously unable to do so?**<br>_____ |
| **Dressing:** The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances. | • Able to perform independently and without any assistance.<br>• Able to perform with aid of special equipment<br>• Always require another person's assistance throughout the entire activity | **Yes / No**<br>**Yes / No**<br>**Yes / No** | **(a) Reasons**<br>_____<br>_____<br>**(b) Date of disability First occurred (ddmmyyyy)**<br>☐☐☐☐☐☐☐☐<br>**(c) For how long has he/she been continuously unable to do so?**<br>_____ |
| **Transferring**: The ability to move from a bed to an upright chair or wheelchair and vice versa. | • Able to perform independently and without any assistance.<br>• Able to perform with aid of special equipment<br>• Always require another person's assistance throughout the entire activity | **Yes / No**<br>**Yes / No**<br>**Yes / No** | **(a) Reasons**<br>_____<br>_____<br>**(b) Date of disability First occurred (ddmmyyyy)**<br>☐☐☐☐☐☐☐☐<br>**(c) For how long has he/she been continuously unable to do so?**<br>_____ |

| | | | |
|---|---|---|---|
| **Mobility:** The ability to move indoors from room to room on level surfaces. | • Able to perform independently and without any assistance.<br>• Able to perform with aid of special equipment<br>• Always require another person's assistance throughout the entire activity | **Yes** / **No**<br>**Yes** / **No**<br>**Yes** / **No** | **(a) Reasons**<br>_____<br>_____<br>**(b) Date of disability First occurred (ddmmyyyy)**<br>☐☐☐☐☐☐☐☐<br>**(c) For how long has he/she been continuously unable to do so?**<br>_____ |
| **Toileting:** The ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene. | • Able to perform independently and without any assistance.<br>• Able to perform with aid of special equipment<br>• Always require another person's assistance throughout the entire activity | **Yes** / **No**<br>**Yes** / **No**<br>**Yes** / **No** | **(a) Reasons**<br>_____<br>_____<br>**(b) Date of disability First occurred (ddmmyyyy)**<br>☐☐☐☐☐☐☐☐<br>**(c) For how long has he/she been continuously unable to do so?**<br>_____ |
| **Feeding:** The ability to feed oneself once food has been prepared and made available. | • Able to perform independently and without any assistance.<br>• Able to perform with aid of special equipment<br>• Always require another person's assistance throughout the entire activity | **Yes** / **No**<br>**Yes** / **No**<br>**Yes** / **No** | **(a) Reasons**<br>_____<br>_____<br>**(b) Date of disability First occurred (ddmmyyyy)**<br>☐☐☐☐☐☐☐☐<br>**(c) For how long has he/she been continuously unable to do so?**<br>_____ |

2) What tests did you use to establish the patient's function for each of the ADLs mentioned above (e.g. standardised functional assessments, observation of patient performaing ADL-specific tasks, etc.)?

3) If your assessment of the patient's function for each of the ADLs was taken from report(s) provided by the patient or relatives, please attach a copy of such report(s).

4) Is there anything in the patient's **lifestyle** or **personal medical history** which would have increased the patient's risk of suffering from Parkinson's disease? If "Yes", please give details: ❒ Yes ❒ No

| Type of Lifestyle / Exact diagnosis | Date of diagnosis | Name of doctor & Address of hospital/clinic |
|---|---|---|
| | | |

5) Is there anything in the patient's **family history** which would have increased the patient's risk of suffering from Parkinson's disease? If "Yes", please give details: ❒ Yes ❒ No

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

6) a) Is the patient mentally incapacitated? ❒ Yes ❒ No

b) If the patient is mentally incapacitated, is he/she mentally capable of receiving or handling money? ❒ Yes ❒ No

7) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for for the **Parkinson's disease** or any other related diseases? If "Yes", please give details: ❒ Yes ❒ No

| Name of doctor and Address of hospital/clinic | Date **First** & **Last** consulted | Reasons for consultation |
|---|---|---|
| | | |

8) Has the patient ever been hospitalised for Parkinson's Disease or its related 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 |
|---|---|---|---|
| | | | |

9) Is the patient's diagnosis directly or indirectly, wholly or partly caused by or arising from or contributed to by:

i) Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) infection? ❒ Yes ❒ No

If "Yes", please provide details:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Date of Diagnosis of AIDS/HIV (ddmmyyyy): | | | | | | | | |
| Date the patient **First** became aware of the condition (ddmmyyyy): | | | | | | | | |



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ii) wilful misuse of drugs? ❒ Yes ❒ No

iii) wilful misuse of alcohol? ❒ Yes ❒ No

iv) congenital anomaly or defect? ❒ Yes ❒ No

If "Yes" for any of the above, please provide the details including diagnosis date, name of doctor and clinic who **First** diagnosed the patient with HIV or AIDS, wilful misuse of drugs, wilful misuse of alcohol or congenital anomaly or defect. Please provide copy of test result.

9) Please provide us with any other additional information that will enable the Company to assess the claim.

10) Please enclose a copy of all reports including specialist or hospital reports, magnetic resonance imaging, computerised tomography or other reliable imaging techniques, 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) | |