Disability and/or Terminal Illness Claims
Doctor's Statement

Important
Please attach copies of all medical reports, including laboratory test results, diagnostic report, biopsy and/or histopathology report, ultrasound report, coronary angiography, isotope studies imaging, CT scans, and relevant hospital reports that are available. The cost of the doctor's statement and/or medical evidence shall be borne by the claimant.

Patient's particulars

Name of Patient

NRIC/FIN/Passport

Gender ☐ Male ☐ Female

Patient's medical records

Are you the patient's usual medical doctor? ☐ Yes ☐ No

If no, please provide name and clinic address of patient's regular doctor who is assisting in treatment or after care.

Name of Doctor

Name and Address of Clinic/Hospital

Date of first consultation with you (dd/mm/yyyy)

Date of last consultation (Dd/mm/yyyy)

Reason for consultations with date

Date of first hospitalisation
(dd/mm/yyyy)

Date of recent hospitalisation
(dd/mm/yyyy)

Is there a history of this condition or any condition likely to have contributed to or be connected with the patient's present condition? ☐ Yes ☐ No

If yes, please provide detail of the conditions/diagnosis, date of diagnosis, consultations and treatment, name of doctor and clinic/hospital address

Name of Doctor

Name and Address of Clinic/Hospital

Conditions/Diagnosis

Date of conditions/ diagnosis

Consultations and treatment

Date of treatment
(dd/mm/yyyy)

Have you referred the patient to any other doctor?

Referral Date

Reason

Name of Doctor

Name and Address of Clinic/Hospital

Please describe and elaborate on the nature and severity of the patient's physical disability and limitation

Please provide in detail the treatment prescribed with dates, including type of operation performed, rehabilitation programs (e.g. physiotherapy number of cycles, commencement and termination date), medication, etc

In accordance with Singapore's mental capacity act (CAP177A), is the patient mentally incapacitated?

Please advise the patient's cognitive and mental abilities

Other Information about patient

Nature of duties of current occupation

How does the patient's disability prevent him/her from performing the above listed duties of his/her occupation?

Is the patient able to perform all the normal duties of his usual occupation? ☐ Yes ☐ No

Expected to return to his/her usual occupation (dd/mm/yyyy)

If unable to return, is he/she able to engage in any other occupation? ☐ Yes ☐ No

What type of occupation can he/she engage in?

When is he/she expected to engage in these occupations (dd/mm/yyyy)?

Is the patient physically or mentally incapacitated from ever continuing in any employment? ☐ Yes ☐ No

If "yes", when did such disability commence (dd/mm/yyyy)

Is the disability "total and permanent" and such that there is neither then nor at any time thereafter any work, occupation or profession that the patient can ever sufficiently do or follow to earn or obtain any wages, compensation or profits? ☐ Yes ☐ No

If "yes", when did such disability commence? (dd/mm/yyyy)

Detail of current disability/ illness

Date of first consultation of this current condition (dd/mm/yyyy)

Detail of symptoms presented during first consultation

If the date is unknown, please state how long the symptoms had been present prior to the date of first consultation

Underlying cause of the symptoms	
Exact diagnosis of the condition	
ICD-10 code (if applicable)	
Date of diagnosis (dd/mm/yyyy)	
Date when patient first became aware of symptoms (dd/mm/yyyy)	

Please provide name/address of the doctor who first diagnosed the patient with this condition

Name of Doctor	
Name and Address of Clinic/Hospital	

Did the patient consult other doctors for this condition or symptom before he/she consulted you?

Name of Doctor	
Name of Clinic/Hospital	
Date of first consultation	

When was the referral made for the patient to see you? What reason? Please attach a copy of the referral letter. Please provide name and practice address of referral doctor

Name of doctor	
Name and Address of Clinic/Hospital	

Is the patient suffering or has he/she suffered from any other significant illnesses? ☐ Yes ☐ No

If "yes", please provide the following information:

Name of Doctor

Name and Address of Clinic/Hospital

Conditions/Diagnosis

Date of Conditions/ Diagnosis (dd/mm/yyyy)

Please provide the detail of patient's treatment: date, detail of treatment/investigation/surgery and please enclose the copies of all the relevant test reports

Detail of treatment

Investigation

Surgery

Name of doctor and hospital/clinic where patient received and/or is receiving the above mentioned treatment

Name of Doctor

Name and Address of Clinic/Hospital

What was the patient's response to the treatment?

Are there plans for other forms of treatment? ☐ Yes ☐ No

If "yes", please provide type of treament, expected date of treatment

Type of treatment

Date of treatment (dd/mm/yyyy)

Based on your latest records, has the patient's condition improved, deteriorated or remained stationary: since the disability commenced/since the six months prior to the last consultation at your hospital/clinic.

If recovery can be reasonably expected, please describe the extent of possible recovery in the next 3 to 6 months/6 to 12 months (Please state approximate date (dd/mm/yyyy))

If recovery is not reasonably expected, is the disability total and permanent, and beyond any hope of recovery? ☐ Yes ☐ No

If "yes", please provide the basis of your evaluation

Is the patient following a recommended treatment program? Please comment or describe nature of treatment

Is the patient confined to a home, hospital or other institution that provides constant care and medical attention? ☐ Yes ☐ No

If "yes", please provide the following information:

Date of Residing (dd/mm/yyyy)

Name and Address of Home/Hospital/Institution

In your opinion, is the condition highly likely to lead to death within the next 12 months. If "yes", please provide details on the basis of your evaluation.

Please state date of your most recent clinical/diagnostic examination (dd/mm/yyyy).
Please explain and give supporting medical evidence to substantiate your opinion

Was the patient recommended to receive medical advice, tests, treatment, diagnosis or prescribed drugs within the last 12 months? If "yes", please specify

Please **circle** as applicable in relation to the patient's Activities of Daily Living (ADLs) ability based on the **latest** visit			Please provide details
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. • Able to perform with the aid of special equipment. • Always require the physical assistance of another person throughout the entire activity.	Yes / No Yes / No Yes / No	
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. • Able to perform with the aid of special equipment. • Always require the physical assistance of another person throughout the entire activity.	Yes / No Yes / No Yes / No	
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. • Able to perform with the aid of special equipment. • Always require the physical assistance of another person throughout the entire activity.	Yes / No Yes / No Yes / No	
Mobility – the ability to move indoors from room to room on level surfaces.	• Able to perform independently and without any assistance. • Able to perform with the aid of special equipment. • Always require the physical assistance of another person throughout the entire activity.	Yes / No Yes / No Yes / No	
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. • Able to perform with the aid of special equipment. • Always require the physical assistance of another person throughout the entire activity.	Yes / No Yes / No Yes / No	
Feeding – the ability to feed oneself once food has been prepared and made available.	• Able to perform independently and without any assistance. • Able to perform with the aid of special equipment. • Always require the physical assistance of another person throughout the entire activity.	Yes / No Yes / No Yes / No	

Detail of surgical procedures and treatment

Type of operation	Date performed	Name of surgeon	Name of anesthetist

Details of disability/illness if due to an accident

Is the condition a result of an accident? ☐ Yes ☐ No

Date/time of accident

Place of the accident

Please describe how the accident occurred

Please describe the nature and extent of injuries sustained

Was the patient under the influence of alcohol and/or drugs at the time of accident. If "yes", please elaborate (e.g. result of blood alcohol concentration, alcohol breath test, name of drug, quantity consumed, etc)

Patient's other information

Is the patient suffering from total and irrecoverable loss of use of both eyes or two limbs or one eye & one limb, excluding hands & feet? Please provide the disability commenced date (dd/mm/yyyy)

If the disability is pertaining to total & permanent loss of sight, please provide the full details.

If the disability is pertaining to loss of physical function/severance of limbs, please provide the full details.

Is the patient suffering from total loss of hearing in both the ears? Please provide the actual reading on the extent of hearing loss for both ears.

Is the patient suffering from total loss of ability to speak? Please provide detail

Is the patient's disability/terminal illness arising directly or indirectly out of attempted suicide or self-conflicted injuries/is AIDS-related? Please provide details of diagnosis, date of diagnosis, name of treating doctor and address of clinic/hospital

Please provide any other information that will enable the company to assess this claim

Doctor's certification

I hereby certify that I have personally examined and treated the patient for the above condition and the answers given represent my medical opinion of his/her condition.

Signature of doctor

Name and designation of doctor

Name of clinic/hospital and stamp

Date (dd/mm/yyyy)