Section IV - Attending Physician Statement (Other Critical Illness Claims)

(Applicable to Burns, Lung Disease, Liver Failure, Kidney Failure, Deafness/Loss of Hearing, Blindness/Loss of Sight, Loss of Speech, Medullary Cystic Disease, Major Organ / Bone Marrow Transplant, Loss of Independent Existence, Chronic Aplastic Anemia, Fulminant Viral Hepatitis, Systemic Lupus Erythematosus, Terminal Illness, HIV Infection Due To Blood Transfusion and Occupationally Acquired Human Immunodeficiency Virus (HIV) Infection)

Claim No: ________________________ Policy No: ______________________

The completion of this form is at the expense of the patient.

Patient's Information	
Name:	IC No:
Date of Admission:	Date of Discharge:

Patient's Medical Information	
1) Please provide full and exact details of the diagnosis.	2) Was the patient referred by any other doctor or hospital? ☐ Yes ☐ No If yes, please state name of the doctor and hospital: Date of first consultation with you: (DD/MM/YY)
3) Date of injury or symptom(s) first appeared: (DD/MM/YY)	
4) Please state the symptoms presented during the first consultation.	
5) To your best knowledge, has the patient ever had the same or similar condition(s) or symptom(s)? ☐ Yes ☐ No If yes, please state dates and conditions/symptoms:	6) Was the condition caused by any underlying disease? If yes, please specify:

7) Is the diagnosis due to or associated with any of the following?

(a) Congenital anomalies?	☐ Yes	☐ No	(e) Refractive error or correction of eyesight?	☐ Yes	☐ No
(b) Heredity condition?	☐ Yes	☐ No	(f) Cosmetic or plastic surgery?	☐ Yes	☐ No
(c) Pregnancy or childbirth?	☐ Yes	☐ No	(g) Routine medical check-up?	☐ Yes	☐ No
(d) Drugs or alcohol?	☐ Yes	☐ No	(h) Mental or nervous disorders?	☐ Yes	☐ No

8) Brief Discharge summary including type of treatment(s), investigations, test, results and/or any complications and follow-up plan.

9) Did the patient undergo any surgical procedure as a result of the diagnosis/illness?

☐ Yes ☐ No

If yes, please describe the following:

i) Name and nature of the procedure:

ii) Date of operation: (DD/MM/YY)

10) Can the patient undertake the following activities on their own (whether aided or unaided)? If yes, please tick.

- ☐ Washing - 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
- ☐ Dressing - the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances
- ☐ Feeding - the ability to feed oneself once food has been prepared and made available;
- ☐ Toileting - the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene
- ☐ Mobility - the ability to move indoors from room to room on level surfaces; and
- ☐ Transferring - the ability to move from a bed to an upright chair or wheelchair and vice versa

Date of Assessment: __________________

11) Please tick (/) and complete the relevant sections (if applicable):

☐ **Burns** ☐ 1st degree ☐ 2nd degree ☐ 3rd degree

Please indicate the percentage (%) of the burns of the body surface? ________________

☐ **Lung Disease : Stage** _________
Please tick (/) if the patient met the following criteria :

- ☐ The need for regular oxygen treatment on a permanent basis
- ☐ Permanent impairment of lung function with a consistent Forced Expiratory Volume (FEV) of less than 1 liter during the first second
- ☐ Shortness of breath at rest
- ☐ Baseline Arterial Blood Gas analysis with partial oxygen pressures of 55mmHg or less

☐ **Liver Failure: Stage**__________
Please tick (/) if the patient met the following criteria:

- ☐ Permanent jaundice
- ☐ Ascites (excessive fluid in peritoneal cavity)
- ☐ Hepatic encephalopathy

☐ **Kidney Failure : Stage** _________

i) Date first diagnosed with kidney disease: ____________________
ii) Has the patient's kidney disease reach end-stage? ☐ Yes ☐ No
iii) Are both kidneys involved? ☐ Yes ☐ No
iv) Is regular kidney dialysis being performed? ☐ Yes, since when __________ ☐ No
v) Has the kidney transplantation been performed? ☐ Yes ☐ No

☐ **Deafness/Loss of Hearing**
*Medical evidence in the form of an audiometry and sound-threshold tests result must be provided and certified by an Ear, Nose, and Throat (ENT) specialist Doctor.

i) Please provide full and exact details of the injury, disease or condition causing deafness including the dates of consultation.

____

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ii) Is the deafness/loss of hearing permanent and irresible?

i) Left Ear ☐ Yes ☐ No
ii) Right Ear ☐ Yes ☐ No

iii) What is the degree of hearing loss in all frequency of hearing using sound threshold tests in both ears?

i) Left ear ___________________dB
ii) Right ear ___________________dB

☐ **Blindness/Loss of Sight**
i) Please provide full and exact details of the injury, disease or condition causing deafness including the dates of consultation.

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ii) Is the loss of sight permanent and irreversible?

i) Left Eye ☐ Yes ☐ No
ii) Right Eye ☐ Yes ☐ No

iii) What is the visual acuity of both eyes based on the last assessment (using Snellen eye chart)?

	Left Eye	Right Eye
Visual Acuity		

iv) Last Assessment Date: ______________________

☐ **Loss of Speech**
i) Please provide full and exact details of the injury, disease or condition causing loss of speech including the dates of consultation.

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ii) Is the loss of speech permanent and irreversible? ☐ Yes ☐ No

iii) Last Assessment Date: ______________________

12) If there is any further information which is in your opinion will assist us in assessing the claim, please furnish us such information.

Please enclose copies of all reports, including X-Ray, blood test, other laboratory tests, cystoscopy report, pyelograms, ultrasound and biopsy reports, surgical procedures and any relevant hospital reports that are available.

1	Burns	Total Body Surface Area Burn Assessment report
2	Lung Disease	Pulmonary Function Test result, Arterial Blood Gas test result, FEV 1 test result and all relevant investigation results
3	Liver Failure	Liver Function Test, CT scan of Liver, all laboratory, pathology, hepatitis screening, ultrasound and histology report
4	Kidney Failure	Kidney Dialysis report, Kidney transplantation report, Blood test results and copy of bill and original receipts
5	Deafness / Loss of Hearing	Pure Tone Audiometry Test and Sound, Threshold Test results and Brainstem Auditory Evoked Response (BAER) report
6	Blindness/Loss of Sight	Visual Acuity report on both eyes to be done by an ophthalmologist. Assessment report to be completed by an Ophthalmologist.
7	Loss of speech	Laryngoscopy report and report by speech Pathologist/Therapist
8	Medullary Cystic Disease	Renal Biopsy report
9	Major Organ / Bone Marrow Transplant	Surgical report
10	Loss of Independent Existence	CT Scan / MRI report, Ultrasound report, Surgery report, Blood test reports
11	Chronic Aplastic Anemia	Bone Marrow Aspiration Report, Blood transfusion records, Bone Marrow transplant report, Full Blood Picture reports
12	Fulminant Viral Hepatitis	Liver Function Test results, CT Scan Report of Liver, Abdominal ultrasound, Hepatitis viral serology test, Any other laboratory or pathology reports
13	Systemic Lupus Erythematosus	Lupus Erythematosus (LE) cell blood test result, Anti-DNA Antibodies, Urine FEME results over past 6 months, Renal function tests with eGFR results over past 6 months, Renal biopsy report
14	Terminal Illness	All relevant investigation results in support of the diagnosis
15	HIV Infection Due To Blood Transfusion	HIV antibody test by ELISA method on the date of blood transfusion, HIV antibody test by ELISA method 3 - 6 months from date transfusion, Statement from statutory Health Authority to confirm that the disease was medically acquired, Western Blot test
16	Occupationally Acquired Human Immunodeficiency Virus (HIV) Infection	HIV antibody test by ELISA method on the date of blood transfusion, HIV antibody test by ELISA method 3 - 6 months from date transfusion, Statement from statutory Health Authority to confirm that the disease was occupationally acquired, Western Blot test

Declaration		
I hereby certify that the facts given above are true to the best knowledge.		
Signature and Stamp:	Name of attending physician/specialist:	Date:
Qualification:	Telephone No:	Hospital: