CRITICAL ILLNESS CLAIM - DOCTOR'S STATEMENT

Bone, Joint, Muscle and Connective Tissue Related Conditions

Note: This form is to be completed at the Patient's expense by the Attending Physician/ Surgeon.

PRUDENTIAL

Patient's Personal Details

Name

Policy Number

NRIC/Old IC/Passport/Birth Cert/Others

Date of Birth

Gender ☐ Male ☐ Female

The claim is being filed for the following illness: (Please tick [✓] in the appropriate box)

	Sections to be completed
☐ Paralysis of Limbs / Loss of Use of One Limb	A, B, K & L
☐ Loss of Limbs/ Fingers	A, C, K & L
☐ Surgical Reattachment of Amputated Limb	A, C, K & L
☐ Loss of a Single Hand/ Foot by Amputation	A, C, K & L
☐ Limb Amputation due to Type 2 Diabetic Complications	A, C, K & L
☐ Muscular Dystrophy (Moderate/ Severe)	A, D, K & L
☐ Rheumatoid Arthritis (Moderate/ Severe/ Chronic)	A, E, K & L
☐ Joint Replacement due to Severe Osteoarthritis	A, F, K & L
☐ Total Knee/ Hip Replacement	A, F, K & L

	Sections to be completed
☐ Osteoporotic Fracture Requiring Surgery	A, G, K & L
☐ Osteoporotic (Severe) Fracture of The Hip/ Vertebra	A, G, K & L
☐ Osteogenesis Imperfecta	A, G, K & L
☐ Poliomyelitis (Moderate/ Severe)	A, H, K & L
☐ Progressive Scleroderma (Early/ Late)	A, I, K & L
☐ Progressive Scleroderma With CREST Syndrome	A, I, K & L
☐ Mild / Moderately Severe / Third Degree Burns	A, J, K & L
☐ Grafting due to Burns	A, J, K & L
☐ Tracheostomy	A, J, K & L

Note: Assessment of claims and provision of benefits will be based on the Policy mentioned in this form.

SECTION A : Medical Record of the Patient

1. Are you the patient's regular/ family doctor?

☐ YES ☐ NO

If Yes, over what period do your records extend?

Day Month Year

2. Date the patient first consulted you this illness / injury.

Day Month Year

3. The presenting signs and symptoms during the first consultation with you.

4. The date when the patient first noticed the presenting signs and symptoms.

Day Month Year

5. In your opinion, how long have the presenting signs and symptoms lasted prior to the first consultation with you?

Day Month Year

6. Please describe the full and exact diagnosis and treatment advice was given.

Diagnosis Date (DD/MM/YYYY)	Diagnosis	Treatment Advice

7. Date when the patient was informed of the diagnosis.

Day Month Year

8. Which of the following factors are present? For factors which are present, please provide the date of onset.

i. Hypertension ☐ YES ☐ NO Day Month Year

ii. Diabetes Mellitus ☐ YES ☐ NO Day Month Year

iii. Hyperlipidemia ☐ YES ☐ NO Day Month Year

iv. Others, please specify Day Month Year

SECTION B ▪ **Paralysis of Limbs** ▪ **Loss of Use of One Limb**

M. What was the condition of the patient on the last consultation?

Last Consultation Date (DD/MM/YYYY)	Condition

H. What is the cause of the paralysis?

☐ Illness ☐ Accident

If caused by *illness*, please provide details.

If caused by *accident*, please provide details.

Date of Accident (DD/MM/YYYY)	Details of the incident	Details of the injury

3. Was there evidence of self-inflicted injury?

☐ YES ☐ NO

If Yes, please provide details.

4. Please indicate the examination of limbs' Muscle Power and Range of Movement of the various joints in the table below.
(muscle power; with the rating 1 being the lowest & 5 being the highest. Range of movement; the maximum degree of movement that is doable by the joints)

Joints	Muscle Power		Range of Movement	
	Right	Left	Right	Left
Shoulder				
Elbow				
Wrist				
Grip				
Hip				
Knee				
Ankle				

5. Please indicate the activities of daily living (ADL) that the patient is NOT able to perform without the assistance of another person, with or without the use of mechanical equipment, special devices or other aids and adaptations. Please tick the appropriate ADL.

☐ Transfer – Getting in and out of a chair without requiring physical assistance
☐ Mobility – Abillity to move from room to room without requiring physical assistance
☐ Continence – Ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene
☐ Dressing - Putting on and taking off all necessary items of clothing without requiring assistance from another person
☐ Bathing/Washing – Ability to wash in the bath or shower (including getting in and out of the bath or shower) or wash by any other means
☐ Eating - All tasks of getting food into the body once it has been prepared

6. Is the inability to perform the ADL indicated above expected to be permanent and irreversible?

☐ YES ☐ NO

If No, please elaborate

7. Is the loss of use of the involved limbs considered total, permanent and irreversible?

☐ YES ☐ NO

If Yes, please state the limbs involved and provide bases for prognosis.

Please provide details of all investigations conducted. (E.g. Radiological, CT scanning, Imaging reports Blood and laboratory test results, Surgical reports, All Neurological reports and relevant reports,Police Report, etc.)

SECTION C

- **Loss Of Limbs / Fingers**
- **Surgical Reattachment Of Amputated Limb**
- **Loss Of A Single Hand/ Foot By Amputation**
- **Limb Amputation Due To Type 2 Diabetic Complications**

1. Was any limb(s) amputated or severed?

☐ YES ☐ NO

If Yes, please provide details of limbs involved.

2. What was the cause leading to amputation?

☐ Injury ☐ Accident ☐ Self-inflicted ☐ Others

Please give details.

3. Was there any surgery to reattach / reimplant the limb(s) following complete amputation?

☐ YES ☐ NO

If Yes, please state the limb(s) and the site of implantation, date of surgery and name of hospital in which surgery was performed.

Date of Surgery (DD/MM/YYYY)	Limb(s) and Site of Implantation	Name of Hospital

4. What treatment is being rendered?

5. What is the prognosis?

Please provide details of all investigations conducted. (E.g. Radiological, CT scanning, Imaging reports Blood and laboratory test results, Surgical reports, All Neurological reports and relevant reports,Police Report, etc.)

SECTION D ▪ **Muscular Dystrophy (Moderate / Severe)** ***(To be completed by the Neurologist)***

1. Please provide details of, including dates of the extent of the neurological deficit.

Date (DD/MM/YYYY)	Extent of The Neurological Deficit

2. Which type of Muscular Dystrophy did the patient suffer from?

3. Are the neurological deficits likely to be permanent?

☐ YES ☐ NO

If Yes, please elaborate.

4. Is there any evidence of sensory disturbances, abnormal cerebrospinal fluid or diminished tendon reflex?

☐ YES ☐ NO

If Yes, please specify the nerve involved (central or peripheral) and describe findings

5. Was there wasting and weakness of the muscles? Please state the power of the affected muscles, with 1 being the lowest and 5 being the highest.

Date (DD/MM/YYYY)	Affected Muscle(s) & Muscle(s) Power

6. Please indicate the activities of daily living (ADL) that the patient is NOT able to perform without the assistance of another person, with or without the use of mechanical equipment, special devices or other aids and adaptations. Please tick the appropriate ADL.

- ☐ Transfer – Getting in and out of a chair without requiring physical assistance
- ☐ Mobility – Abillity to move from room to room without requiring physical assistance
- ☐ Continence – Ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene
- ☐ Dressing - Putting on and taking off all necessary items of clothing without requiring assistance from another person
- ☐ Bathing/Washing – Ability to wash in the bath or shower (including getting in and out of the bath or shower) or wash by any other means
- ☐ Eating - All tasks of getting food into the body once it has been prepared

7. Is the inability to perform the ADL indicated above expected to be permanent and irreversible?

☐ YES ☐ NO

If No, please elaborate

8. Was there any investigation tests done to confirm the diagnosis? If Yes, please enclose copy of the results.

☐ Electromyogram ☐ Muscle Biopsy ☐ Others, please specify

9. Is there any family history of similar or related illness?

☐ YES ☐ NO

If Yes, please state the relationship, nature of illness and the date the illness was first diagnosed, if known.

Please provide details of all investigations conducted. (E.g. Blood tests, Radiological, CT scanning, Imaging reports Muscle Biopsy / Histopathology Report Laboratory Reports Clinical Presentation Report, Neurological tests & Medical Reports certified by Neurologist, Electromyogram, etc.)

SECTION E ▪ Rheumatoid Arthritis (Moderate / Severe / Chronic)

1. Was there any blood tests and/or investigation tests to confirm the diagnosis?

☐ YES ☐ NO

If Yes, please state the type of investigation, date performed, results and enclose copy of the results.

If No, please explain how the diagnosis was confirmed.

2. Were the following symptoms/ signs present?

i. Morning joint stiffness	☐ YES	☐ NO	
ii. Symmetric arthritis of joints	☐ YES	☐ NO	If No, please clarify.
iii. Presence of rheumatoid nodules	☐ YES	☐ NO	If Yes, please state location.
iv. Elevated titres of rheumatoid factor	☐ YES	☐ NO	***If Yes, please attach results.***
v. Radiographic evidence of joint destruction	☐ YES	☐ NO	***If Yes, please attach radiographic reports.***

3. Was there deformity noted clinically of the following joint areas? Please attach all the imaging evidences of the joint destructions

- ☐ Hands
- ☐ Wrists
- ☐ Elbows
- ☐ Cervical spine
- ☐ Knees
- ☐ Ankles
- ☐ Metatarsophalangeal joints in the feet

4. Please indicate the activities of daily living (ADL) that the patient is NOT able to perform without the assistance of another person, with or without the use of mechanical equipment, special devices or other aids and adaptations. Please tick the appropriate ADL.

- ☐ Transfer – Getting in and out of a chair without requiring physical assistance
- ☐ Mobility – Abillity to move from room to room without requiring physical assistance
- ☐ Continence – Ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene
- ☐ Dressing - Putting on and taking off all necessary items of clothing without requiring assistance from another person
- ☐ Bathing/Washing – Ability to wash in the bath or shower (including getting in and out of the bath or shower) or wash by any other means
- ☐ Eating - All tasks of getting food into the body once it has been prepared

5. Is the inability to perform the ADL indicated above expected to be permanent and irreversible?

☐ YES ☐ NO

If No, please elaborate

Please attach certified true copies of all relevant reports. (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Surgery reports or hospital records, etc.)

SECTION F ▪ Joint Replacement Due to Severe Osteoarthritis

1. Which joint was affected by Osteoarthritis?

☐ Hip ☐ Shoulder
☐ Knee ☐ Others, please specify:

2. Was there any investigation tests done to confirm the diagnosis? If Yes, please enclose copy of the results.

☐ YES ☐ NO

If No, please explain how the diagnosis was confirmed.

3. Was there an evidence of a complete loss of articular surface (joint space) from X-ray investigation?

☐ YES ☐ NO

If Yes, please provide details and enclose copy of X-ray results.

4. Did the patient undergo surgery of full joint replacement with prosthesis ?

☐ YES ☐ NO

If Yes, is this the first time the patient undergo surgery?

☐ YES ☐ NO

If Yes, please indicate which joint and provide details of the surgery (I.e. type of surgery, date of surgery and the hospital where it was performed).

Date of Surgery (DD/MM/YYYY)	Type of Surgery	Hospital

If No, please state whether surgery is planned and to provide the date surgery is planned.

Please attach certified true copies of all relevant reports. (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Surgery reports or hospital records, etc.)

SECTION G
- **Osteoporotic Fracture Requiring Surgery**
- **Osteoporotic Fracture Of The Hip/ Vertebra**
- **Osteogenesis Imperfecta**

1. Was bone mineral density test conducted?

☐ YES ☐ NO

If Yes, please provide the T-score and Z-score test results, date conducted and attach copy of the report.

i. T-score reading ____ Date Conducted ____ Day ____ Month ____ Year

ii. Z-score reading ____ Date Conducted ____ Day ____ Month ____ Year

If No, please clarify how the condition was diagnosed. Please attach copy of the results in support of the diagnosis.

2. Was there any skin biopsy done?

☐ YES ☐ NO

If Yes, please state the finding(s) and provide imaging report indicating the fracture.

3. Was there any fracture?

☐ YES ☐ NO

If Yes, please state the site of fracture and provide imaging report indicating the fracture.

What was the cause of the fracture?

☐ Osteoporosis ☐ Osteogenesis Imperfecta

Please provide information for the underlying cause.

4. What was the treatment for the fracture?

5. If surgery was performed, please provide details of the surgery.

Date of Surgery (DD/MM/YYYY)	Type of Surgical Procedure	Doctor & Hospital Name

Please attach certified true copies of all relevant reports. (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Surgery reports or hospital records, Police Report, skin biopsy etc.)

SECTION H ▪ Poliomyelitis *(To be completed by the Neurologist)*

1. Is there paralysis?

☐ YES ☐ NO

If Yes, please describe the extent of the Paralysis

Limb	Muscle Power
	/5

2. Was there impaired motor function or respiratory weakness?

☐ YES ☐ NO

If Yes, please provide details

3. What is the underlying cause of the paralysis?

i. Polio Virus ☐ YES ☐ NO If Yes, please provide laboratory evidence.

ii. Guillain-Barre Syndrome ☐ YES ☐ NO If Yes, please provide details.

iii. Injury ☐ YES ☐ NO If Yes, please provide details

iv. Others, to provide details. ☐ YES ☐ NO If Yes, please attach radiographic reports.

4. Is the condition associated with any underlying causes or condition or related to any congenital condition?

☐ YES ☐ NO

If Yes, please provide details.

5. What treatment has been and is currently being administered?

6. Is there anything in the patient's habits, family history or personal medical history which would have increased the risk of poliomyelitis?

☐ YES ☐ NO

If Yes, please provide details.

Please attach certified true copies of all relevant reports. (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Surgery reports or hospital records, etc.)

SECTION I ▪ **Progressive Scleroderma**

1. Which form of scleroderma does the patient have?

i. Localized Scleroderma ☐ YES ☐ NO If Yes, please specify area.

ii. Systemic Scleroderma ☐ YES ☐ NO If Yes, please specify area.

2. Does the condition fall within any of the following?

i. Localised Scleroderma (Linear scleroderma or morphea) ☐ YES ☐ NO

ii. Eosoniphilic Fasciitis ☐ YES ☐ NO

iii. CREST Syndrome ☐ YES ☐ NO

3. Please describe the extent of the illness.

i. Was the heart involved? ☐ YES ☐ NO

ii. Were the lungs involved? ☐ YES ☐ NO

iii. Were the kidneys involved? ☐ YES ☐ NO

iv. Skin? ☐ YES ☐ NO

v. Blood Vessels? ☐ YES ☐ NO

vi. Others, to specify ☐ YES ☐ NO

4. Please provide results of all investigations performed and enclose copies of reports.

i. Serology

ii. Biopsy

iii. Imaging

iv. Other Blood test

5. Please provide details of treatment administered (E.g. immunosuppressive agents, etc).

Please attach certified true copies of all relevant reports. (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Surgery reports or hospital records, etc.)

SECTION J
- **Major Burns/ Third Degree Burns**
- **Moderately Severe Burns**
- **Skin Grafting Due To Burns**
- **Tracheostomy**

1. Please describe the incident/ accident leading to the burn injury.

2. Please state the extent of the burn in terms of depth and size (percentage of affected body surface, please use Lund-Browder chart).

Depth of Burn	Areas Affected & Percentage of Affected
First Degree	
Second Degree	
Third Degree	
Fourth Degree	

3. Was the burn a full thickness burn?

☐ YES ☐ NO

4. Did the burn involve patient's face?

☐ YES ☐ NO

If Yes, please provide the extent of the burns (in percentage) for patient's face only. %

5. Was there skin grafting done?

☐ YES ☐ NO

If Yes, please provide details of the area where skin grafting was done.

6. Was there any Tracheostomy done for ventilatory support?

☐ YES ☐ NO

If Yes, please select ONE applicable reason for the tracheostomy done & the period of use,

i. Trauma / Accident ☐

ii. Major Burns ☐

iii. Illness ☐

The period of use : ☐ Hour ☐ Day ☐ Month ☐ Year

7. Was there other surgical intervention done besides the skin grafting and Tracheostomy? Please provide details if there is any

Please attach certified true copies of all the relevant investigation results. (E.g. Lund and Browder Body Surface Chart Radiological, CT scanning, Imaging reports, Surgical reports Blood and Laboratory evidence, Police Report, or etc.)

SECTION K : Others Medical Information

1. Has the patient previously suffered from this illness or any related illness or any other illnesses?

☐ YES ☐ NO

If Yes, please provide details as required below :

Date of Consultation (DD/MM/YYYY)	Illness/ Diagnosis	Types of Treatment Received/ Details of Hospitalisation	Investigation Result	Name of Doctor & Name of Hospital/ Medical or Healthcare Facilities

2. Was the patient referred to you?

☐ YES ☐ NO

If Yes, please provide details below and enclose a copy of the referral letter (if any):

Name & Address of Referral Doctor

SECTION L : Attending Doctor's Declaration

I hereby certify that:

☐ I am the patient's attending doctor and I have personally examined and treated the patient for the illnesses/ injuries sustained; OR

☐ I have personally perused the patient's medical records;

and that the facts as stated above are all true to the best of my knowledge and information that I have perused.

Signature : Date :

Name :

Professional Qualification :

MMC/ Registration Number :

Name & Address of Hospital/ Clinic :

Official Stamp of the Hospital/ Doctor :