

# PAEDIATRICIAN - DOCTOR'S STATEMENT

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



## Patient's Personal Details

Name	Policy Number	
<input type="text"/>	<input type="text"/>	
NRIC/Old IC/Passport/Birth Cert/Other	Date of Birth	Gender
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female

## SECTION A : Medical History of the Patient

### 1. Hospitalisation

Admission Date	:	<input type="text"/> Day	<input type="text"/> Month	<input type="text"/> Year
Discharge Date	:	<input type="text"/> Day	<input type="text"/> Month	<input type="text"/>
Year	ICU/HDU/NICU (if applicable)			
From	:	<input type="text"/> Day	<input type="text"/> Month	<input type="text"/> Year
To	:	<input type="text"/> Day	<input type="text"/> Month	<input type="text"/> Year
Incubation (if applicable)				
From	:	<input type="text"/> Day	<input type="text"/> Month	<input type="text"/> Year
To	:	<input type="text"/> Day	<input type="text"/> Month	<input type="text"/> Year

### 2. Was the patient born prematurely?

Yes  No

If Yes, please state the gestational period and circle the applicable term.

Weeks / Months

### 3. Presenting signs and symptoms (inclusive of Duration):

### 4. The following records upon the admission:

i. Blood Pressure	<input type="text"/>	mmHg
ii. Temperature	<input type="text"/>	°C
iii. Pulse	<input type="text"/>	beat per minute

### 5. Final diagnosis

### 6. Is the final diagnosis related to any of the following? ( Please indicate [✓] or circle the relevant )

<input type="checkbox"/>	Alcohol or Substance Abuse/ Addiction of the baby's mother
<input type="checkbox"/>	Complication resulting from fertility treatment including in vitro fertilization
<input type="checkbox"/>	Baby's mother has AIDS / is HIV positive
<input type="checkbox"/>	Suicide or attempted suicide while sane or insane /Self-inflicted injuries of the baby's mother

### 7. Was the patient referred to you?

YES  NO

If Yes, please enclose a copy of the referral letter (if any) and answer the following:

a) Name of referred doctor / clinic

b) Address of the clinic

FORM ID 11601087

8. Has the patient been hospitalised for the same illness whether in this hospital or any other hospitals?

YES  NO

If Yes, please state details of previous admission as below :

Date of Admission (DD/MM/YYYY)	Hospital	Diagnosis / Illness	Treatment

9. Is the patient suffering from any other underlying illnesses besides the current medical condition?

YES  NO

If Yes, please provide details :

Date of Diagnosis (DD/MM/YYYY)	Underlying Illness	Doctor's Name / Address / Telephone No

10. Please state all investigations, tests or procedures which had been performed. *Please attach a copy of all the test results.*

Date (DD/MM/YYYY)	Name of investigation / test / procedure	Doctor's Name / Address / Telephone No

11. Nature of treatment given and Date (DD/MM/YYYY)

Date (DD/MM/YYYY)	Nature of Treatment

12. For Surgery :

Date of surgery performed (DD/MM/YYYY)	Nature of operation performed	Name of surgeon	Type of implant (if any)

13. Type of child developmental disorder the patient is diagnosed with:

**Sections to be completed:**

- |  |          |
|--|----------|
| <input type="checkbox"/> Attention Deficit Hyperactivity Disorder (ADHD) | A, B & I |
| <input type="checkbox"/> Gross Motor or Speech Developmental Delay       | A, C & I |
| <input type="checkbox"/> Language Disorder                               | A, D & I |
| <input type="checkbox"/> Severe Autism Spectrum Disorder (ASD)           | A, E & I |
| <input type="checkbox"/> Specific Learning Disorder                      | A, F & I |
| <input type="checkbox"/> Stereotypic Movement Disorder                   | A, G & I |
| <input type="checkbox"/> Tourette Syndrome                               | A, H & I |

**SECTION B - Attention Deficit Hyperactivity Disorder (ADHD)**

1. Type of ADHD the patient is diagnosed with:

- Combined Presentation: Has presented symptoms of both Inattentive and Hyperactive-Impulsive.  
 Predominantly Inattentive Type: Has presented symptoms of inattention, but not hyperactivity-impulsivity.  
 Predominantly Hyperactive-Impulsive Presentation: Has presented symptoms of hyperactivity-impulsivity, but not inattention.

2. Choose any additional Conditions / Criterias:

- Symptoms are not a reflection of oppositional behavior.  
 Symptoms interfere with school, work, or social functioning.  
 Symptoms are not caused by physiological effects of a substance.  
 Symptoms are not resulted other medical condition.  
 Symptoms are not resulted from other mental condition.

3. Patient's age when first noticed the presenting symptoms: \_\_\_\_\_

4. Is patient currently on stimulants therapy?

YES  NO

If yes, please provide the following:

i. Date of patient starts stimulants therapy.

Day  Month  Year

ii) Details of medication.

5. How long has the patient on stimulants therapy without interruption?

Day  Month  Year

6. Name of therapist/doctor and speciality.

**SECTION C**      ▪      **Gross Motor or Speech Developmental Delay**

1. Is patient able to perform the following tasks? (Please tick [✓] in the appropriate box)

Assessment of following task must be performed to Life Assured attained the age of twenty-eight (28) months or older.

Yes	No	Task
<input type="checkbox"/>	<input type="checkbox"/>	Walk up several steps of a staircase by himself or herself. The wall or rail may be used for support but not aided by a person.
<input type="checkbox"/>	<input type="checkbox"/>	Walk without aid over a distance of two (2) meters.
<input type="checkbox"/>	<input type="checkbox"/>	Say at least three (3) words other than "Papa/Mama"
<input type="checkbox"/>	<input type="checkbox"/>	Speak simple words such as "Papa/Mama"
<input type="checkbox"/>	<input type="checkbox"/>	Use spontaneous (non-echoed/non-imitated) 2- word phrases.

2. Was there any identifiable post-natal cause resulting in the inability to perform any of the above tasks?

YES  NO

If yes, to specify: \_\_\_\_\_

3. Name of therapist/doctor and speciality.

**SECTION D**      ▪      **Language Disorder**

1. The presenting signs and symptoms. (Please tick [✓] in the appropriate box)

The individual has a consistently hard time using language in different manners (speaking, writing, using sign language, or other) due to deficits in understanding or production that include:

- Reduced vocabulary.  
 Limited sentence structure or limited ability to put words together to form basic, grammatically correct sentences.  
 Impairments in discourse, for limited ability to use vocabulary and connect sentences or to keep up good conversation.

The individual's language capacity is significantly below what is expected at his or her age, which may result in hindered communication, social participation, and academic achievement.

The symptoms set in during the individual's early developmental period.

These given difficulties are not result of a sensory impairment, motor dysfunction, or another medical condition, and cannot be attributed to intellectual disability or global developmental delay.

2. Is patient undergoing any therapeutic interventions?

YES  NO

If yes, to specify type of therapy.

3. Name of therapist/doctor and speciality

4. Is the condition related to any of the following? If yes, please tick [✓] the applicable option.

- Symptoms occur during the course of another disorder. Please specify the name of disorder: \_\_\_\_\_
- Physiological effects of a substance.
- Another neurodevelopment disorder.
- Mental disorder.
- Underlying cerebral palsy.
- Underlying stroke.
- Learning difficulties.
- Psychosocial adversity.
- Tic disorder excluding Tourette Syndrome.
- Lack of proficiency in the language of academic instruction or inadequate education instruction.

**SECTION E      ▪      Severe Autism Spectrum Disorder (ASD)**

1. A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history. (Tick [✓] in the appropriate box)

- A1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
- A2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
- A3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least 2 of 4 symptoms, currently or by history (Tick [✓] in the appropriate box)

- B1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
- B2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).
- B3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest).
- B4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

C. Is the symptom(s) present in the early developmental periods? (But may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life.)

- YES       NO

If yes, provide patient age of first symptoms develop: \_\_\_\_\_

D. Is there any clinically significant impairment in social, occupational, or other important areas of current functioning?

- YES       NO

If yes, to describe the impacted areas: \_\_\_\_\_

2. Is patient's condition accompanying with the following disability / disorder? (Please tick [✓] in the appropriate box)

- Intellectual disability. Please specify IQ score: \_\_\_\_\_
- Significant permanent motor deficits.
- Epilepsy disorder.

3. Classify severity of patient Autism Spectrum Disorder (ASD):

	Level 1 "Requiring support"	Level 2 "Requiring substantial support"	Level 3 "Requiring very substantial support"
Social Communication			
Restricted Repetitive Behavior			

4. Is patient currently on pharmacologic and non-pharmacologic treatment regime for ASD?

- YES       NO

If yes, to provide details of treatment provided: \_\_\_\_\_

5. Name of therapist/doctor and speciality.

**SECTION F**      ▪      **Specific Learning Disorder**

1. The presenting signs and symptoms. (Please tick [✓] in the appropriate box)  
Difficulties learning and using academic skills, as indicated by the presence of at least one of the following symptoms that have persisted for at least 6 months, despite the provision of interventions that target those difficulties:
- Inaccurate or slow and effortful word reading (e.g. - reads single words aloud incorrectly or slowly and hesitantly, frequently guesses words, has difficulty sounding out words).
  - Difficulty understanding the meaning of what is read (e.g. - may read text accurately but not understand the sequence, relationships, inferences, or deeper meanings of what is read).
  - Difficulties with spelling (e.g. - may add, omit, or substitute vowels or consonants).
  - Difficulties with written expression (e.g. - makes multiple grammatical or punctuation errors within sentences; employs poor paragraph organization; written expression of ideas lacks clarity).
  - Difficulties mastering number sense, number facts, or calculation (e.g. - has poor understanding of numbers, their magnitude, and relationships; counts on fingers to add single-digit numbers instead of recalling the math fact as peers do; gets lost in the midst of arithmetic computation and may switch procedures).
  - Difficulties with mathematical reasoning (e.g. - has severe difficulty applying mathematical concepts, facts, or procedures to solve quantitative problems).

2. Are the affected academic skills substantially and quantifiably below those expected for the individual's chronological age, and cause significant interference with academic or occupational performance, or with activities of daily living?

YES       NO

If yes, provide more details: \_\_\_\_\_

3. Are the learning difficulties begin during school-age years?

YES       NO

If yes, provide age of patient affected condition started: \_\_\_\_\_

4. Is the condition related to any of the following? If yes, please tick [✓] the applicable option.
- Symptoms occur during the course of another disorder. Specify the name of disorder: \_\_\_\_\_
  - Physiological effects of a substance.
  - Another neurodevelopment disorder.
  - Mental disorder.
  - Underlying cerebral palsy.
  - Underlying stroke.
  - Learning difficulties.
  - Psychosocial adversity.
  - Tic disorder excluding Tourette Syndrome.
  - Lack of proficiency in the language of academic instruction or inadequate education instruction.

5. Is patient undergoing any therapeutic interventions?

YES       NO

If yes, specify type of therapy.

6. Name of therapist/doctor and speciality.

**SECTION G**      ▪      **Stereotypic Movement Disorder**

1. The presenting signs and symptoms. (Please tick [✓] in the appropriate box)
- Repetitive, seemingly driven, and apparently purposeless motor behavior (e.g., hand shaking or waving, body rocking, head banging, self-biting, hitting own body).
  - The repetitive motor behavior interferes with social, academic, or other activities and may result in self-injury.
  - Onset is in the early developmental period.

2. Is the condition related to any of the following? If yes, please tick the applicable option.

- Symptoms occur during the course of another disorder. Specify the name of disorder: \_\_\_\_\_
- Physiological effects of a substance.
- Another neurodevelopment disorder.
- Mental disorder.
- Underlying cerebral palsy.
- Underlying stroke.
- Learning difficulties.
- Psychosocial adversity.
- Tic disorder excluding Tourette Syndrome.
- Lack of proficiency in the language of academic instruction or inadequate education instruction.

3. Is patient undergoing any therapeutic interventions?

- YES  NO

If yes, specify type of therapy.

4. Name of therapist/doctor and speciality.

**SECTION H      ▪      Tourette Syndrome**

1. Patient presented with: (Please tick [✓] in the appropriate box)

- Motor tics (for example, blinking or shrugging the shoulders).
- Vocal tics (for example, humming, clearing the throat, or yelling out a word or phrase).
- Have had tics for at least a year (occur many times a day (usually in bouts) nearly every day, or off and on).
- Have tics that begin before 18 years of age. Specify age of patient begins to have tics: \_\_\_\_\_

2. Does patient have tics continuously without interruption for a certain period after the diagnosis?

- YES  NO

If yes, specify duration of event.

Day  Month  Year

3. Has patient received the following medication(s) without interruption?

Yes	No	Medication
<input type="checkbox"/>	<input type="checkbox"/>	Alpha2-adrenergic agonists
<input type="checkbox"/>	<input type="checkbox"/>	Muscle relaxants
<input type="checkbox"/>	<input type="checkbox"/>	Dopamine antagonists

If yes, to provide details of medication provided.

4. Duration of treatment as of today.

Day  Month  Year

5. Name of therapist/doctor and speciality.

**SECTION I : 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.

If you are not the attending doctor, please state:

The Attending Doctor's Name & Speciality:

The reason(s) for completing this document on behalf of the Attending Doctor:

Signature : Date :  
Name :  
Professional Qualification :  
MMC/ Registration Number :  
Name & Address of Hospital/ Clinic :  
Official Stamp of the Doctor :