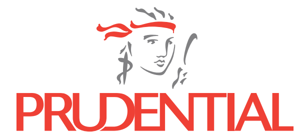
CRITICAL ILLNESS CLAIM - DOCTOR'S STATEMENT



Brain and Nerve Related Conditions

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

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)

	Illness	Sections to be completed
☐	Apallic Syndrome	A, B, N & O
☐	Encephalitis	A, C, N & O
☐	Meningitis/ Bacterial Meningitis	A, C, N & O
☐	Brain Surgery	A, D, N & O
☐	Insertion of Cerebral Shunt	A, D, N & O
☐	Insertion of Ventriculoperitoneal Shunt	A, D, N & O
☐	Endovascular Treatment of Cerebral AVM	A, D, N & O
☐	Craniotomy for Treatment of Aneurysm/ AVM	A, D, N & O
☐	Benign Tumour of The Brain/ Benign Brain Tumour	A, E, N & O
☐	Surgical Excision of a Spinal Meningioma	A, E, N & O
☐	Surgery for Drug Resistant Epilepsy	A, F, N & O
☐	Major Head Trauma	A, G, N & O
☐	Surgical Repair of Depressed Skull Fracture	A, G, N & O
☐	Motor Neuron Disease	A, H, N & O
☐	Multiple Sclerosis	A, I, N & O
☐	Parkinson's Disease	A, J, N & O
☐	Early Stage / Moderately Severe Parkinson's Disease	A, J, N & O
☐	Alzheimer's Disease	A, K, N & O
☐	Moderately Severe Alzheimer's Disease or Dementia	A, K, N & O
☐	Stroke	A, L, N & O
☐	Carotid Artery Surgery	A, L, N & O
☐	Coma	A, M, N & O

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 for 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

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SECTION B ▪ Apallic Syndrome

1. Please provide the name and address of the doctor who diagnosed the patient of Apallic Syndrome.

2. Please state the clinical manifestations exhibited by the patient and date on the last consultation.

Clinical Manifestations Exhibited	Date (DD/MM/YYYY)

3. Please provide details and enclose reports of any imaging tests done.

4. How long has the condition been medically documented?

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

☐ YES ☐ NO

If Yes, please provide details.

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

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT scanning, Imaging reports Surgery report or hospital reports, Blood and laboratory test results, etc.)

SECTION C ▪ Encephalitis ▪ Meningitis / Bacterial Meningitis

1. What was the causative agent of the infection?

☐ Bacterial
☐ Virus
☐ Fungus
☐ Others, please specify

2. Was lumbar puncture performed? If Yes, please submit the CSF investigation reports (including C&S).

☐ YES ☐ NO

3. Was there any significant neurological deficit?

☐ YES ☐ NO

If Yes, please provide details.

4. For how long was the neurological deficit noted? Please state the duration.

From ____ Day ____ Month ____ Year To ____ Day ____ Month ____ Year

a. Is such impairment expected to be permanent? ☐ YES ☐ NO

b. Is there hope of recovery with current medical knowledge and technology? ☐ YES ☐ NO

5. Is the patient HIV positive?

☐ YES ☐ NO

If Yes, please provide the date that the patient was first diagnosed of HIV positive.

____ Day ____ Month ____ Year

6. Is the Encephalitis/ Meningitis a result of HIV infection?

☐ YES ☐ NO

If No, please elaborate.

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7. Which of the following Activities of Daily Living (ADL) is the patient NOT able to perform? Please tick [✓] as appropriate.

- [ ] 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 maiintain 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

8. Is the inability to perform the above ADL expected to be permanent?

☐ YES ☐ NO

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT scanning, Imaging reports Surgery report or hospital reports, Blood and laboratory test results, etc.)

SECTION D

- **Brain Surgery**
- **Insertion of Cerebral Shunt**
- **Insertion of Ventriculoperitoneal Shunt**
- **Endovascular Treatment of Cerebral AVM**
- **Craniotomy for Treatment of Aneurysm / AVM**

1. Did the patient undergo surgery of the brain?

☐ YES ☐ NO

If Yes, please provide details of surgery

Date of Surgery (DD/MM/YYYY)	Reason of the Surgery

2. Was there head trauma leading to the surgery?

☐ YES ☐ NO

If Yes, please provide details.

3. Was a Cerebral Shunt implanted during the surgery?

☐ YES ☐ NO

If Yes, please provide reason for the shunt.

4. Which of the following surgical approach/ procedure was performed ?

i. Craniotomy	☐ YES	☐ NO
ii. Burr Hole	☐ YES	☐ NO
iii. Transphenoidal	☐ YES	☐ NO
iv. Endovascular Treatment	☐ YES	☐ NO
v. Other Minimal Invasive Procedure	☐ YES	☐ NO

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Biopsy/ Histopathology report, Surgery reports and/or hospital record, Craniotomy surgery report for Brain Surgery, Police Report for Major Head Trauma, etc.)

SECTION E

- **Benign Tumour of The Brain/ Benign Brain Tumour**
- **Surgical Excision of a Spinal Meningioma**

1. Where was the location of the tumour?

☐ Brain ☐ Spine

2. What is the nature of the tumour?

☐ Benign ☐ Malignant

3. Was there any damage to the brain?

☐ YES ☐ NO

4. Is the presence of the underlying tumour confirmed by CT scan, MRI or other imaging studies?

☐ YES ☐ NO

If Yes, please enclose copies of all investigation performed ie biopsy results, cytology reports, CT scan, MR imaging, etc

5. Is the tumour life-threatening in nature ?

☐ YES ☐ NO

If Yes, please elaborate.

6. Are there characteristic signs of intra-cranial pressure ?

☐ YES ☐ NO

If Yes, Were the below symptoms/ signs present?

i. Papilloedema ☐ YES ☐ NO

ii. Any mental symptoms ☐ YES ☐ NO

iii. Seizures ☐ YES ☐ NO

iv. Sensory Impairment ☐ YES ☐ NO

v. Others, to specify ________

7. Was the neurological deficit permanent with persisting clinical symptoms ?

☐ YES ☐ NO

If Yes, please provide details.

8. Has the tumour been surgically removed either totally or partially ?

☐ YES ☐ NO

If Yes, please provide surgery date, hospital in which it was performed and details of histology.

Date of Surgery (DD/MM/YYYY)	Hospital	Details of Histology

9. Is the diagnosis falling within any of the following conditions?

i. Cysts ☐ YES ☐ NO

ii. Granulomas ☐ YES ☐ NO

iii. Malformations in or of the arteries or veins of the brain ☐ YES ☐ NO

iv. Haematomas ☐ YES ☐ NO

v. Tumours of the pituitary gland ☐ YES ☐ NO

vi. Tumours of the spine ☐ YES ☐ NO

vii. Tumours of the acoustic nerve ☐ YES ☐ NO

viii. Tumours of the meninges ☐ YES ☐ NO

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Biopsy/ Histopathology report, Surgery reports and/or hospital record, Craniotomy surgery report for Brain Surgery, Police Report for Major Head Trauma, etc.)

SECTION F ▪ Surgery for Drug Resistant Epilepsy

1. What was the type of Epilepsy?

☐ Grand Mal/ Tonic Clonic Seizure ☐ Petit Mal/ Absence Seizure ☐ Others, please specify ________

2. Please provide details of the consultation for the past 2 years, including the presentation of the epilepsy and medication prescribed.

Consultation Date (DD/MM/YYYY)	Presenting Symptoms	Treatment and Medications

3. Could the epilepsy be controlled by oral medication?

☐ YES ☐ NO

If No, please elaborate.

4. Was there any surgery performed to the brain tissue for the patient's Epileptic condition?

☐ YES ☐ NO

If Yes, please provide details of the surgery.

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

Please attach copies of all the relevant reports of tests available. (I.e. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Biopsy/ Histopathology report, Surgery reports and/or hospital record, Craniotomy surgery report for Brain Surgery, Police Report for Major Head Trauma, etc.)

SECTION G ▪ Major Head Trauma ▪ Surgical Repair of Depressed Skull Fracture

1. Is there any injury to the brain tissue?

☐ YES ☐ NO

If Yes, please provide exact nature of brain injury (to enclose copy of MRI or CAT scan).

2. Was there any fracture of the skull bones ? If Yes, please provide details and attach copy of radiological evidence.

☐ YES ☐ NO

3. What was the date of injury?

☐ Day ☐ Month ☐ Year

4. Please provide details of circumstance where the leading to injury.

5. Was a surgery performed?

☐ YES ☐ NO

If Yes, please provide the type of and details of surgery.

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

6. Please provide details of functional impairment and how long the impairment has lasted from date of trauma or injury.

Impairment	Duration (in months)

7. Is such impairment expected to be permanent?

☐ YES ☐ NO

8. Is there hope of recovery with current medical knowledge and technology?

☐ YES ☐ NO

9. What is the prognosis?

10. Kindly describe in detail the disability suffered by the patient that has rendered him permanently disabled when he was last seen by you.

11. Is the patient permanently bedridden as a result of the head trauma?

☐ YES ☐ NO

12. If the patient is not bedridden, please indicate the activities of daily living (ADL) that the patient is not able to perform. 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 maiintain 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

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Biopsy/ Histopathology report, Surgery reports and/or hospital record, Craniotomy surgery report for Brain Surgery, Police Report for Major Head Trauma, etc.)

SECTION H ▪ Motor Neuron Disease

1. Please specify the types of Motor Neurone Disease.

i. Spinal Muscular Atrophy	☐ YES	☐ NO
ii. Progressive Bulbar Palsy	☐ YES	☐ NO
iii. Amyotrophic Lateral Sclerosis	☐ YES	☐ NO
iv. Primary Lateral Sclerosis	☐ YES	☐ NO

2. Please provide details of, including dates of the extent of the neurological deficit and clinical signs according to your consultation records.

Date (DD/MM/YYYY)	Clinical signs / Neurological Deficit

3. Are the above neurological deficits likely to be permanent?

☐ YES ☐ NO

If yes, please elaborate.

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

5. Is there anything in the patient's habits or personal medical history which would have increased the risk of motor neuron disease?

☐ YES ☐ NO

If Yes, please provide details.

6.Does the patient have or ever had any other significant health condition?

☐ YES ☐ NO

If Yes, please provide details of the condition, including diagnosis, date of diagnosis and treatment received.

7. Are you aware of any blood relative suffering from 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 copies of all investigation reports. (E.g. gelectromyography, biopsy, nerve conduction studies, MRI, etc) and all relevant reports (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Surgery reports or hospital records, etc.)

SECTION I ▪ Multiple Sclerosis

1. Was there involvement of the optic nerves, brain stem and spinal cord?

☐ YES ☐ NO

If Yes, please provide details.

2. Was there impairment of co-ordination and motor sensory function?

☐ YES ☐ NO

If Yes, how long has the symptoms lasted and please provide details.

3. Please provide details of consultation dates and extent of the patient's neurological deficit.

Date (DD/MM/YYYY)	Extent Neurological Deficit

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4. Is there a history of exacerbations and remissions of neurological signs?

☐ YES ☐ NO

If Yes, please provide details including dates of each episode.

5. Was there evidence of multiplicity or discrete lesions on imaging studies? If Yes, please provide copies of reports.

☐ YES ☐ NO

6. Please provide details of any confirmatory investigations performed.

7. Is the patient confined to a wheelchair?

☐ YES ☐ NO

If Yes, for how long? ☐ Day ☐ Month ☐ Year

Please provide 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

- **Parkinson's Disease**
- **Early Stage Parkinson's Disease**
- **Moderately Severe Parkinson's Disease**

1. What was the underlying cause of the disease?
   - i. Idiopathic ☐ YES ☐ NO
   - ii. Drug-induced, please specify the drug ☐ YES ______ ☐ NO
   - iii. Toxins, please give details ☐ YES ______ ☐ NO

2. Was there permanent clinical impairment of motor function associated with
   - i. Tremor ☐ YES ☐ NO
   - ii. Rigidity of Movement ☐ YES ☐ NO
   - iii. Postural Instability ☐ YES ☐ NO

3. Is the patient treated with medication?

☐ YES ☐ NO

If Yes, please provide the details.

Name of Medication	Duration of Consumption

4. Was the disease well controlled by medication?

☐ YES ☐ NO

If Yes, please provide details.

5. Was there signs of progressive impairment?

☐ YES ☐ NO

If Yes, please provide details.

6. Is the patient able to perform the following activities without assistance?

Activities of Daily Living	YES / NO	Description for the condition
Transfer (Getting in & out of a chair without requiring physical assistance)	☐ YES ☐ NO	
Mobility (The ability to move from room to room without requiring any physical assistance)	☐ YES ☐ NO	
Continence (The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene)	☐ YES ☐ NO	
Dressing (Putting on and taking off all necessary items of clothing without requiring assistance of another person)	☐ YES ☐ NO	
Bathing/ Washing (The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means)	☐ YES ☐ NO	
Eating (All tasks of getting food into the body once it has been prepared)	☐ YES ☐ NO	

Please provide copies of all relevant reports. (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, All Neurological reports and relevant reports, All hospital reports or relevant reports, Cerebral Angiogram, etc.)

SECTION K ▪ Alzheimer's Disease ▪ Moderately Severe Alzheimer's Disease or Dementia

1. What was the underlying cause of the dementia?

i. Alzheimer's Disease	☐ YES		☐ NO
ii. Vascular Dementia, please give details	☐ YES		☐ NO
iii. Neurosis or Psychiatric Illness, please give details	☐ YES		☐ NO
iv. Drug related Brain Disorder, please specify the drug	☐ YES		☐ NO
v. Alcohol related Brain Damage, please give details	☐ YES		☐ NO

2. Is there a permanent clinical loss of ability to do all of the following ?

i. Remember	☐ YES	☐ NO
ii. Reason	☐ YES	☐ NO
iii. Perceive, understand, express and give effect to ideas	☐ YES	☐ NO

3. Was there significant reduction in mental and social functioning?

i. Deterioration or loss of intellectual capacity	☐ YES	☐ NO
ii. Abnormal behavior	☐ YES	☐ NO

4. Does the patient require continuous supervision?

☐ YES ☐ NO

If Yes, please provide details.

5. Is the disease reversible?

☐ YES ☐ NO

Please provide the score for Mini-mental state examination (MMSE) and all supporting clinical questionnaires / test results including imaging reports. (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, All Neurological reports and relevant reports, Cerebral Angiogram, All questionnaires and test reports, etc.)

SECTION L ▪ Stroke ▪ Carotid Artery Surgery

1. Patient's physical and mental status on last consultation

i. Physical

ii. Mental

2. Is there continuous improvement in the signs/symptoms of the patient's neurological deficit ?

☐ YES ☐ NO

3. Please provide the details below.

a. Did the patient suffer from a neurological deficit?	☐ YES	☐ NO	If Yes, please state the duration of deficit. ☐ Hours ☐ Days
b. If the patient is suffering from coma, how long was the patient in coma?	☐ YES	☐ NO	If Yes, please state the duration. ☐ Months
c. Are the neurological deficit permanent and with persisting clinical symptoms/ signs?	☐ YES	☐ NO	If Yes, please describe the persisting symptoms/ signs.
d. Is the patient still on follow-up treatment ?	☐ YES	☐ NO	If Yes, please provide the last follow up date. ☐ Day ☐ Month ☐ Year

4. Please provide the most recent date that a complete neurological assessment was done.

☐ Day ☐ Month ☐ Year

5. When do you think the patient would recover from the neurological deficits (if any) as a result of the stroke.

☐ Day ☐ Month ☐ Year

6. Please confirm if the neurological deficits would most likely be persistent throughout the lifetime of the patient.

☐ YES ☐ NO

7. If unable to answer question (5) and (6) above, please suggest a date that the patient will undergo another neurological assessment.

☐ Day ☐ Month ☐ Year

8. What was the underlying cause of the condition?

- [ ] Infarction of brain tissue
- [ ] Arterio-venous Malformation
- [ ] Embolization from an extra-cranial source
- [ ] Head injury
- [ ] Cerebral Haemorrhage
- [ ] Carotid artery narrowing
- [ ] Others, to specify

9. Is the diagnosis falling within any of the following conditions?

i. Transient Ischaemic Attack	YES	NO
ii. Any reversible ischaeic neurological deficit	YES	NO
iii. Vertebrobasilar ischaemia	YES	NO
iv. Cerebral symptoms due to migraine	YES	NO
v. Cerebral injury resulting from trauma or hypoxia	YES	NO
vi. Vascular disease affecting the eye or optic nerve or vestibular functions	YES	NO

10. Was there narrowing of the carotid artery ?

YES NO

If Yes, please provide percentage of narrowing.

%

11. Did the patient suffer stroke as a result of the carotid artery narrowing?

YES NO

12. Did the patient undergo Endarterectomy of the Carotid Artery?

YES NO

If No, please clarify.

Please provide copies of all relevant reports (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, All Neurological reports and relevant reports, Carotid Artery surgery report, etc.)

SECTION M ▪ Coma

1. Date and time of onset.

Day Month Year am/pm

2. Was the patient put on life support system ?

YES NO

If Yes , for how long.

Hours

3. What is the extent of coma under the Glasgow Coma Scale or any other measurement for coma ? Please state type of measurement.

4. Please provide the date and time of emergence from coma and resulting patient's limitations both physical and mental since then.

Day Month Year am/pm

Limitation:

5. Are there any neurological deficits lasting more than 30 days after the patient awoke from coma / regain consciousness?

YES NO

If Yes, please provide details of neurological deficit and duration of the deficit.

6. Is the coma resulting from any of the following?

i. Alcohol	YES	NO
ii. Drug abuse/ misuse	YES	NO
iii. Self-inflicted injury	YES	NO
iv. Medically induced	YES	NO

Please provide copies of all relevant reports. (E.g. Hospital bills on Life Support Systems billing, Glasgow Coma Scale Report certified by a Neurologist, Radiological, CT scanning, Imaging reports, Laboratory reports as well as any other tests certified by a Neurologist, etc.)

SECTION N : 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 O : 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 Doctor :

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