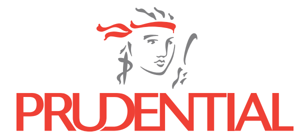
CRITICAL ILLNESS CLAIM - DOCTOR'S STATEMENT

Kidney, Liver and Lung Related Conditions

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



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
☐ End Stage Kidney Failure	A, B, O & P
☐ Chronic Severe Renal Impairment	A, B, O & P
☐ Severe Diabetic Nephropathy resulting in Kidney Failure	A, B, O & P
☐ Systemic Lupus Erythematosus (SLE) with Lupus Nephritis	A, C, O & P
☐ Systemic Lupus Erythematosus (SLE) with Severe Kidney Complications	A, C, O & P
☐ Medulla Cystic Disease	A, D, O & P
☐ Nephrectomy/ Removal of one Kidney	A, E, O & P
☐ End Stage Liver Failure	A, F, O & P
☐ Fulminant Viral Hepatitis	A, F, O & P

	Sections to be completed
☐ Cirrhosis of the Liver	A, F, O & P
☐ Partial Hepatectomy	A, G, O & P
☐ Portal Vein Thrombosis	A, H, O & P
☐ End Stage Lung Disease	A, I, O & P
☐ Primary Pulmonary Arterial Hypertension	A, J, O & P
☐ Removal of one Lobe of the Lungs	A, K, O & P
☐ Status Asthmaticus	A, L, O & P
☐ Surgical Insertion of a Vena-cava Filter	A, M, O & P
☐ Heart Failure due to Chronic Lung Disease	A, N, O & P

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

. 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
- End Stage Kidney Failure
- Chronic Severe Renal Impairment
- Severe Diabetic Nephropathy resulting in Kidney Failure

1. Please provide details inclusive of first/ initial presentation (symptoms/signs), diagnosis, treatments, leading to chronic renal failure.

Date (DD/MM/YYYY)	Symptoms/ Signs	Diagnosis	Treatment

2. What is the underlying cause of Chronic Kidney Disease? Please tick the relevant and provide the date of onset.

☐ Lupus Nephritis ☐ Day ☐ Month ☐ Year

☐ Medullary Cystic Disease ☐ Day ☐ Month ☐ Year

☐ Diabetes Mellitus ☐ Day ☐ Month ☐ Year

☐ Inherited/ Hereditary/ Congenital disease, Please provide details

☐ Others, please elaborate

3. What is the stage of the renal failure?

Please attach the results of Renal Function Tests. (E.g. eGFR, bilirubin, albumin creatinine ratio) upon diagnosis of the Chronic Renal Failure and the latest results. (For at least six months from the date the chronic renal failure was first diagnosed.)

4. Is the patient currently undergoing haemodialysis or peritoneal dialysis?

☐ YES ☐ NO

If Yes, please provide details below and enclose copy of haemodialysis card or medical bill of the dialysis.

Date Started (DD/MM/YYYY)	Type of Dialysis	Frequency (No. of times per week)

5. Has renal transplantation been performed?

☐ YES ☐ NO

If Yes, please state date of renal transplantation and hospital in which it was performed.

Date Started (DD/MM/YYYY)	Hospital Name

If No, please state if renal transplantation is planned.

☐ YES, Please provide evidence of official waiting list as recipient. ☐ NO

Please attach certified true copies of all relevant reports. (E.g. Renal Biopsy, Blood and Laboratory test results (for SLE – blood test on antibodies), Ultrasound/ Imaging study of Kidney, Haemodialysis card, Renal Function Test with Electrolytes report, etc.)

SECTION C
- Systemic Lupus Erythematosus (SLE) with Lupus Nephritis
- Systemic Lupus Erythematosus (SLE) with Severe Kidney Complications

1. Please describe the extent of the disease and to state clinical manifestations exhibited by the patient. (E.g. Malar Rash, Photosensitivity, etc.)

2. Was the SLE diagnosed by a Rheumatologist?

☐ YES ☐ NO

If Yes, please provide the name of Rheumatologist.

3. Please confirm if the patient falls under which class according to the WHO Lupus Classification.

- [ ] Class I (Minimal Change) - Negative, normal urine
- [ ] Class II (Mesangial) - Moderate proteinura, active sediment
- [ ] Class III (Focal Segmental) - Proteinura, active sediment
- [ ] Class IV (Diffuse) - Acute nephritis with active sediment and/or Nephritis syndrome
- [ ] Class V (Membranous) - Nephrotic syndrome or Severe proteinura

4. What is the current treatment?

5. Please provide the details below and enclose copies of the biopsy report and investigation reports.

Date of Biopsy (DD/MM/YYYY)	Biopsy / Investigation Result

Please attach certified true copies of all relevant reports. (E.g. Renal Biopsy, Blood and Laboratory test results (for SLE – blood test on antibodies), Ultrasound/ Imaging study of Kidney, Haemodialysis card, Renal Function Test with Electrolytes report, etc.)

SECTION D ▪ Medulla Cystic Disease

1. Please indicate the clinical manifestation.

- [ ] Anaemia
- [ ] Polyuria
- [ ] Others, please specify

2. Was renal biopsy done?

- [ ] YES
- [ ] NO

If Yes, please provide the biopsy reports.

3. Please provide details inclusive of first/ initial presentation (symptoms/signs), diagnosis, treatments, leading to chronic renal failure.

Date (DD/MM/YYYY)	Symptoms/ Signs	Diagnosis	Treatment

Please enclose Renal Function Test (inclusive of eGFR, Electrolytes), Ultrasound/ Imaging studies of kidney and all relevant reports. (E.g. UFEME, ANA, anti-dsDNA, anti-SM, spot protein/creatinine ratio for SLE, etc.)

SECTION E ▪ Nephrectomy / Removal of one Kidney

1. Please provide details of diagnosis leading to removal of the kidney and enclose surgical report.

- [ ] Illness
- [ ] Accident

Please attach certified true copies of all relevant reports. (E.g. Renal Biopsy, Blood and Laboratory test results (for SLE – blood test on antibodies), Ultrasound/ Imaging study of Kidney, Haemodialysis card, Renal Function Test with Electrolytes report, etc.)

SECTION F ▪ End-Stage Liver Failure (Chronic Liver Disease) ▪ Cirrhosis of the Liver ▪ Fulminant Viral Hepatitis

1. What were the symptoms during last consultation?

	Symptom			
i.	Jaundice	[ ] YES	[ ] NO	If Yes, since when?
ii.	Ascites	[ ] YES	[ ] NO	
iii.	Hepatic Encephalopathy	[ ] YES	[ ] NO	
iv.	Portal Hypertension	[ ] YES	[ ] NO	
v.	Cirrhosis	[ ] YES	[ ] NO	

2. What was the extent of the cirrhosis?

Extent		
i. Whole Liver	[ ] YES	[ ] NO
ii. Partial Liver	[ ] YES	[ ] NO
iii. Local Fibrotic/ Cirrhotic changes	[ ] YES	[ ] NO

3. Was there liver failure?

- [ ] YES
- [ ] NO

If Yes, is the end stage liver failure resulting from any of the following?

Cause	YES/ NO	If Yes, please specify type of virus/ drug/ substance
Viral Infection	☐ YES ☐ NO	
Drug	☐ YES ☐ NO	
Alcohol	☐ YES ☐ NO	
Attempted Suicide	☐ YES ☐ NO	
Poisoning	☐ YES ☐ NO	
Others, please specify	☐ YES ☐ NO	

4. Has the liver failure reached the end stage?

☐ YES ☐ NO

5. Is the encephalopathy a form of Wernicke's encephalopathy?

☐ YES ☐ NO

6. What was the causative agent for the fulminant hepatic failure?

Cause	YES/ NO	If Yes, please specify type of virus/ drug/ substance
Viral Infection	☐ YES ☐ NO	
Drug	☐ YES ☐ NO	
Others, please specify	☐ YES ☐ NO	

7. Is the liver size decreasing? If Yes, please provide series of ultrasound reports indicating the changes in the liver size details.

☐ YES ☐ NO

8. Please describe the extent of the liver necrosis and hepatocellular damage.

9. Is there a deteriorating of liver function? If Yes, Please supply the detailed results of serial liver function test results including bilirubin levels, liver biopsy and laboratory evidence as well as any other tests.

☐ YES ☐ NO

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

SECTION G ▪ Partial Hepatectomy

1. Please provide full and exact diagnosis leading to hepatectomy, including dates of diagnosis.

Diagnosis	Diagnosis Date (DD/MM/YYYY)

2. What was the extent of the hepatectomy?

i. Segment ☐ YES ☐ NO

ii. Whole Lobe ☐ YES ☐ NO

iii. Others, please specify

3. Was the hepatectomy necessitated by

☐ Illness ☐ Accident ☐ Organ Donation

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

SECTION H ▪ Portal Vein Thrombosis

1. What was the underlying cause of the thrombosis of portal vein?

2. Did the thrombosis of the portal vein resulted in,

☐ Ascites ☐ Enlargement of the spleen ☐ Oesophageal varices

Please attach certified true copies of radiological evidence of blockage of portal vein (E.g. C.T, MRI, ultrasound, ultrasonography, etc.) and all relevant reports (E.g. Radiological, CT scanning or Imaging reports, Liver Function Test results, Blood and laboratory test results, etc.)

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SECTION I ▪ End-stage Lung Disease (Chronic Lung Disease)

1. Has the lung disease reached end stage?

☐ YES ☐ NO

If Yes, please state the date.

☐ Day ☐ Month ☐ Year

2. What is the underlying cause leading to respiratory failure?

☐ Airway Disease ☐ Others, please specify. ☐

3. What is the FEV1 test result for the past 6 months?

☐ ≥ 80% predicted value
☐ 50% - 80% predicted value
☐ 30% ≤ FEV1 < 50% predicted value
☐ < 30% predicted value

4. What is the baseline Arterial Blood Gas results?

☐ mmHg

5. Does the patient requires temporary or permanent oxygen treatment for the respiratory failure?

☐ Temporary ☐ Permanent

Please provide details on the oxygen treatment regime.

6. Is there dyspnoea at rest?

☐ YES ☐ NO

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

SECTION J ▪ Primary Pulmonary Arterial Hypertension

1. Is there any underlying cause or conditions or congenital related condition?

☐ YES ☐ NO

If Yes, please provide details.

2. What investigations were performed to determine the condition of Primary Pulmonary Arterial Hypertension? Please state type of investigations, results and enclose copy of all investigation results.

3. Was cardiac catheterization done?

☐ YES ☐ NO

4. Is there any ventricular enlargement? If Yes, please provide investigation results as reference.

☐ YES ☐ NO

5. Please state current condition of the patient in accordance with New York Heart Association or an equivalent classification of cardiac impairment.

☐ Class III ☐ Class IV ☐ Others, please specify.

6. Is the above condition (I.e. Class III or IV permanent and/ or beyond hope of recovery with current medical knowledge and technology?

☐ YES ☐ NO

7. With the Primary Pulmonary Arterial Hypertension, is the patient able to perform his/her usual occupation?

☐ YES ☐ NO

If No, please provide the tasks that the patient is unable to perform.

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

SECTION K ▪ Removal of one Lobe of the Lungs

1. Please provide full and exact diagnosis leading to hepatectomy, including dates of diagnosis.

Diagnosis	Diagnosis Date (DD/MM/YYYY)

2. What was the extent of the removal done?

☐ One Lobe ☐ Two Lobes or More ☐ Others, please specify. ________

3. Please provide details of diagnosis leading to removal of the lobe(s) of the lung(s) and enclose surgical report.

☐ Illness
☐ Accident
☐ Liver Biopsy
☐ Donation

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

SECTION L ▪ Status Asthmaticus

1. Was there status asthmaticus leading to the patient being hospitalised?

☐ YES ☐ NO

If Yes, please provide the hospitalisation dates, hospital & treating doctor.

Admission Date (DD/MM/YYYY)	**Hospital**	**Doctor**

2. Was the patient put on pressure ventilation with a mechanical ventilator?

☐ YES ☐ NO

If Yes, please specify the duration (in hours)

________ hours

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

SECTION M ▪ Surgical Insertion of a Vena-Cava Filter

1. When was the patient first diagnosed of Pulmonary Embolism?

____ Day ____ Month ____ Year

2. What is the underlying cause of Pulmonary Embolism?

____

3. Was there recurrent Pulmonary Embolism?

☐ YES ☐ NO

If Yes, please provide fill details on the recurrent episodes including dates of diagnosis and treatment.

Date (DD/MM/YYYY)	**Treatment**

4. Did the patient undergo surgery for insertion of a vena-cava filter?

☐ YES ☐ NO

If Yes, please provide date of surgery was performed.

____ Day ____ Month ____ Year

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

SECTION N ▪ Heart Failure Due to Chronic Lung Disease

1. The date Chronic Lung Disease was diagnosed.

____ ____ ____ Year

2. What is the underlying cause of Chronic Lung Disease?

____

3. Was there right or left heart failure?

☐ Right ☐ Left

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4. What was the underlying cause of the heart failure?

☐ Heart Disease ☐ Lung Disease

Please elaborate in details.

5. Was the lung disease chronic or irreversible?

☐ Chronic ☐ Irreversible

6. Was the Irreversible Right Ventricular Failure evidenced by

i. Pulmonary Hypertension	☐ YES	☐ NO
ii. Persistent Right Ventricular Dilatation and Hypertrophy	☐ YES	☐ NO
iii. Persistent characteristic ECG changes	☐ YES	☐ NO

Please enclose radiological evidence of blockage of portal vein (E.g. C.T, MRI, Ultrasound, Ultrasonography, etc) and all the relevant reports (E.g. Radiological, CT scanning or Imaging reports, Blood and laboratory test results, Surgery report or hospital reports, etc.)

SECTION O : 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 P : 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 :