INFECTIOUS DISEASE BENEFIT CLAIM - DOCTOR'S STATEMENT

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

PRUDENTIAL

Patient's Personal Details

Name

Policy Number

NRIC/Old IC/Passport/Birth Cert/Other

Date of Birth

Gender ☐ Male ☐ Female

SECTION A : Medical History of The Patient

1. Please select the infectious disease the patient is suffering from:

- ☐ Zika Virus
- ☐ MERS-CoV
- ☐ Ebola
- ☐ SARS
- ☐ Influenza A - Avian Influenza
- ☐ Nipah Virus Encephalitis
- ☐ Japanese Encephalitis
- ☐ Creutzfeldt-Jakob Disease
- ☐ Malaria
- ☐ Measles
- ☐ Hand Foot Mouth Disease
- ☐ Chikungunya Fever
- ☐ Typhoid Fever
- ☐ Rabies

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

☐ YES ☐ NO

If Yes, please state the date of the patient's first visit to you/ your clinic.

Day Month Year

3. Date the patient first consulted you for this condition.

Day Month Year

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

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

Day Month Year

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

Day Month Year

7. Date of diagnosis.

Day Month Year

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

Day Month Year

9. Please state all investigations or tests which had been performed on the patient.

Date (DD/MM/YYYY)	Test/ Laboratory/ Procedure	Investigation Outcome/ Test Result

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10. Was the patient hospitalised for the above condition?

☐ YES ☐ NO

If Yes, please provide hospitalisation details:

i. Admission Date & Time: ☐ Day ☐ Month ☐ Year ☐ am/pm

ii. Discharged Date & Time: ☐ Day ☐ Month ☐ Year ☐ am/pm

11. Please state details and nature of the treatment/ medication given to the patient.

Date (DD/MM/YYYY)	Treatment / Medication

12. Please provide full and exact details of the following:

a. Complications associated to the diagnosis.

b. If diagnosis is **Measles**, please confirm if the condition have resulted in any one of the following complications:

i. Pneumonia ☐ YES ☐ NO

ii. Encephalitis ☐ YES ☐ NO

iii. Singular Convulsions ☐ YES ☐ NO

iv. Hepatitis ☐ YES ☐ NO

c. If diagnosis is **Hand Foot Mouth Disease**, please confirm if the condition has resulted any one of the following:

i. Encephalitis ☐ YES ☐ NO

ii. Myocarditis ☐ YES ☐ NO

iii. Evidence of neurological deficit at least 30 days after the diagnosis ☐ YES ☐ NO

d. If diagnosis is **Chikungunya Fever**, please confirm if the condition has resulted in one of the following complications:

i. Myocarditis ☐ YES ☐ NO

ii. Ocular disease (Uveitis, Retinitis) ☐ YES ☐ NO

iii. Hepatitis ☐ YES ☐ NO

iv. Severe Bullous Lesions ☐ YES ☐ NO

v. Neurologic Disease ☐ YES ☐ NO

e. If diagnosis is **Typhoid Fever**, please confirm if the condition has resulted in one of the following complications:

i. Internal bleeding ☐ YES ☐ NO

ii. Intestinal Perforation ☐ YES ☐ NO

iii. Severe Neuropsychiatric symptoms namely Delirium or Psychosis ☐ YES ☐ NO

13. 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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14. Has the patient previously been treated/ hospitalised whether in this hospital or any other medical/ healthcare facilities for this or related illness/ condition, or any other disorders?

☐ 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	Name of Doctor & Name of Hospital/ Medical or Healthcare Facilities

15. Please enclose copies of all reports, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, etc. and any relevant hospital reports that are available.

SECTION B : 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 :

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