CONGENITAL CONDITION CLAIM - DOCTOR'S STATEMENT

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

PRUDENTIAL

Patient's Personal Details

Name

Policy Number

NRIC/Old IC/Passport/Birth Cert/Other

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:
☐ Cerebral Palsy	A, B & U
☐ Cleft Lip and/or Cleft Palate	A, B & U
☐ Coarctation of the Aorta	A, B & U
☐ Congenital Cataract	A, B & U
☐ Oesophageal Atresia	A, B & U
☐ Retinopathy of Prematurity	A, B & U
☐ Tracheo-oesophageal Fistula	A, B & U
☐ Atrial Septal Defect	A, C & U
☐ Ventricular Septal Defect	A, C & U
☐ Anal Atresia	A, D & U
☐ Congenital Deafness	A, E & U
☐ Congenital Diaphragmatic Hernia	A, F & U
☐ Down's Syndrome	A, G & U
☐ Infantile Hydrocephalus	A, H & U

	Sections to be completed:
☐ Patent Ductus Arteriosus	A, I & U
☐ Spina Bifida	A, J & U
☐ Tetralogy of Fallot	A, K & U
☐ Transposition of the Great Vessels	A, L & U
☐ Truncus Arteriosus	A, M & U
☐ All structural Congenital Conditions	A, N & U
☐ Absence of Two Limbs	A, O & U
☐ Biliary Atresia	A, P & U
☐ Club Foot	A, Q & U
☐ Congenital Abnormalities of the Kidney and Urinary Tract	A, R & U
☐ Congenital Blindness	A, S & U
☐ Congenital Dislocation of Hip / Congenital Hypertrophic Pyloric Stenosis / Development Dysplasia of the Hip	A, T & U

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 usual Medical Attendant?

☐ YES ☐ NO

2. Over what period do your records extend?

First consultation ☐ Day ☐ Month ☐ Year

Last consultation ☐ Day ☐ Month ☐ Year

3. What were the symptoms presented when you first attended the patient? How long has the patient been experiencing the symptoms when you first saw the patient?

Symptom(s)	Duration of Symptom(s)

4. Date when the guardian / parents of patient first became aware of the condition(s).

☐ Day ☐ Month ☐ Year

5. Please describe the full and exact diagnosis.

Diagnosis	Diagnosis Date (DD/MM/YYYY)

6. Date when the guardian / parents of patient was informed of the diagnosis.

☐ Day ☐ Month ☐ Year

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7. Name and practice of doctor(s) who first diagnosed the patient.

8. Please provide the dates and other details of investigations performed.

Date (DD/MM/YYYY)	Test / Laboratory / Imaging

9. Is the diagnosis related to any of the following? (Please tick [✓] and circle the relevant option)

- ☐ Pregnancy resulting from fertility treatment, including in-vitro fertilisation
- ☐ Chosen to have a termination of pregnancy other than for medical reasons
- ☐ Alcohol or Substance Abuse/Addiction
- ☐ AIDS / HIV Positive
- ☐ Violation of laws / Strike / Riots

SECTION B

- **Cerebral Palsy**
- **Cleft Lip and/or Cleft Plate**
- **Coarctation of the Aorta**
- **Congenital Cataract**
- **Oesophageal Atresia**
- **Retinopathy of Prematurity**
- **Tracheo-oesophageal Fistula**

1. Was there any procedure/surgery performed for the congenital condition?

☐ YES ☐ NO

If Yes, kindly provide the Date of Surgery.

☐ Day ☐ Month ☐ Year

2. Please specify the type of procedure/surgery done.

3. Name of surgeon and speciality

4. ***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 C

- **Atrial Septal Defect**
- **Ventricular Septal Defect**

1. Does the patient's condition warrant surgical closure for the reversal of haemodynamic abnormalities and the prevention of heart failure, paradoxic embolisation or irreversible pulmonary vascular disease?

☐ YES ☐ NO

2. The date on which the surgical closure is scheduled to be performed.:

☐ Day ☐ Month ☐ Year

3. What are the further procedures or surgery planned?

4. Please provide details of the patient's current condition.

5. 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 D ▪ **Anal Atresia**

1. Does the patient have high imperforated anus needing colostomy?
   ☐ YES ☐ NO

2. Was there any procedure/surgery performed for the congenital condition?
   ☐ YES ☐ NO

   If Yes, kindly provide the Date of Surgery.
   ☐ Day ☐ Month ☐ Year

3. Kindly specify the type of procedure/surgery done.

4. Name of surgeon and speciality.

5. 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 E ▪ **Congenital Deafness**

1. Did the patient suffer for loss of hearing of both ears present at birth?
   ☐ YES ☐ NO

2. Was there any confinement to a Hospital required directly for the treatment of the congenital deafness?
   ☐ YES ☐ NO

   If Yes, kindly provide the Date of Admission.
   ☐ Day ☐ Month ☐ Year

3. What was the treatment given?

4. Name of doctor and speciality.

5. ***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 F ▪ **Congenital Diaphragmatic Hernia**

1. Was there any presence of abdominal organs in the chest cavity at birth?
   ☐ YES ☐ NO

2. Was the condition associated with pulmonary hypolasia or an underdeveloped heart?
   ☐ YES ☐ NO

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

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SECTION G ▪ Down's Syndrome

1. Is there an extra chromosome 21?

☐ YES ☐ NO

If Yes, ***kindly furnish a copy of the test results confirming the presence of an extra chromosome 21***

2. Does the patient exhibit as listed below:

i) Muscular hypotonicity	☐ YES	☐ NO
ii) Microcephaly	☐ YES	☐ NO
iii) Brachycephaly	☐ YES	☐ NO
iv) Flattened occiput	☐ YES	☐ NO

3. What is the nature and extent of retardation of physical and mental development?

SECTION H ▪ Infantile Hydrocephalus

1. Does the patient have enlargement of the cerebrospinal fluid spaces resulting from obstruction of flow pathway between the secretion sites in the ventricles and absorption sites in the subarachnoid space?

☐ YES ☐ NO

2. Is the patient's condition serious enough to warrant the placement of a shunt?

☐ YES ☐ NO

3. The date on which the surgery is scheduled to be performed.

☐ Day ☐ Month ☐ Year

4. What are the further procedures or surgery planned?

5. Please give details of the patient's current condition.

6. 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 I ▪ Patent Ductus Arteriosus

1. Does the patient's ductus arteriosus fail to close spontaneously?

☐ YES ☐ NO

2. Did the patient start on medication treatment?

☐ YES ☐ NO

If Yes, kindly provide the Date of Treatment done.

☐ Day ☐ Month ☐ Year

3. Kindly specify the type of procedure/surgery done.

4. Name of surgeon and speciality.

5. ***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 J ▪ Spina Bifida

1. Please describe the extent of the defective closure of the spinal column due to a neural tube defect?

2. Did the patient's Spinal Bifida resulted from meningomyelocele or meningocele?

☐ YES ☐ NO

If Yes, please specify.

3. Is the condition associated with neurologicaldeficit?

☐ YES ☐ NO

If Yes, please specify.

4. 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 K ▪ Tetralogy of Fallot

1. Does the patient has any of the anatomic abnormality listed below:

i) Severe or total obstruction of right ventricularoutflow tract	☐ YES	☐ NO
ii) Ventricular septal defect	☐ YES	☐ NO
iii) Dextroposition of the aorta with septal overrid	☐ YES	☐ NO
iv) Right ventricular hypertrophy as confirmed by an echocardiogram	☐ YES	☐ NO

2. 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 L ▪ Transposition of the Great Vessels

1. Does the patient have complete transposition of the aorta and pulmonary artery?

☐ YES ☐ NO

2. Is the above condition associated with any of the items listed below:

i) Right ventricle pump blood from the systemic veins into the aorta?

☐ YES ☐ NO

ii) Left ventricle pump blood from the pulmonary veins into the pulmonary artery?

☐ YES ☐ NO

3. ***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 M ▪ Truncus Arteriosus

1. Did the patient have large ventricular septal defect over which a large, single great vessel (truncus) arises?

☐ YES ☐ NO

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

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SECTION N ▪ **All Structural Congenital Conditions**

1. Please provide the hospitalisation details.

i. Admission Date: ____ Day ____ Month ____ Year

ii. Discharge Date: ____ Day ____ Month ____ Year

2. Describe the full and exact structural congenital condition.

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

Date (DD/MM/YYYY)	Treatment / Medication

4. If surgery was performed, please provide details of surgical procedures rendered.

Date (DD/MM/YYYY)	Nature of Surgical Procedure(s)	Type of Anaesthetic (General/Regional/Local/Sedation)	MMA/PHFSR Code	Name of Surgeon(s)

5. 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 O ▪ **Absence of Two Limbs**

1. The presenting condition at birth. (Please tick [✓] in the appropriate box)

- ☐ absence of both arms at or above the wrist
- ☐ absence of both legs at or above the ankle joints
- ☐ absence of one arm at or above the wrist
- ☐ absence of one leg at or above the ankle joint

SECTION P ▪ **Biliary Atresia**

1. Did patient suffer from jaundice for after birth or appearance of jaundice after two (2) weeks of birth?

☐ YES ☐ NO

If yes, to provide duration of jaundice: _____

2. Patient's direct bilirubin level: _____umol/L

3. Was the following surgery performed for the congenital condition? (Please tick [✓] in the appropriate box)

- ☐ Portoenterostomy
- ☐ Liver transplantation
- ☐ Others. Please specify: _____

4. Enclose copies of all reports, radiological procedures, CT scan, laboratory evidence, other imaging procedure, etc. and any relevant hospital reports that are available.

SECTION Q ▪ **Club Foot**

1. Was patient presented with the following condition(s) at birth? (Please tick [✓] in the appropriate box)

	Unilateral	Bilateral
Plantar flexion		
Inversion of the heel hind foot and forefoot		
Adduction of the forefoot		
Others: _____		

SECTION R ▪ **Congenital Abnormalities of the Kidney and Urinary Tract (CAKUT)**

1. Was patient presented with the following symptoms for at least six (6) months?

Yes	No	Symptoms
		Persistent proteinuria with urine protein to creatinine ratio of above 0.2 mg / mg. Please specify actual protein to creatinine ratio: _____mg/mg
		Elevated estimated creatinine clearance based on serum creatine. Please specify the creatinine level: _____umol/L

2. Date of patient first presented with the above symptoms.

Day ____ Month ____ Year ____

3. Enclose copies of renal scan or magnetic resonance imaging, estimated creatinine clearance test or serum creatinine report.

4. Was there any procedure/surgery performed for the congenital condition?

☐ YES ☐ NO

If yes, kindly provide the date of surgery.

Day ____ Month ____ Year ____

5. Specify the type of procedure/surgery done.

6. Name of surgeon and speciality

SECTION S ▪ **Congenital Blindness**

1. Is the loss of vision presented at birth?

☐ YES ☐ NO

2. Is the loss of vision irreversible?

i. Left eye ☐ YES ☐ NO

ii. Right eye ☐ YES ☐ NO

3. Grade of blindness. (Please tick [✓] in the appropriate box)

i. Left eye

☐ Category 0: No or mild visual impairment –presenting visual acuity better than 6/18
☐ Category 1: Moderate visual impairment –presenting visual acuity worse than 6/18 and better than 6/60
☐ Category 2: Severe visual impairment –presenting visual acuity worse than 6/60 and better than 3/60
☐ Category 3: Blindness –presenting visual acuity worse than 3/60 and better than 1/60
☐ Category 4: Blindness—presenting visual acuity worse than 1/60 with light perception
☐ Category 5: Blindness—irreversible blindness with no light perception

ii. Right eye

☐ Category 0: No or mild visual impairment –presenting visual acuity better than 6/18
☐ Category 1: Moderate visual impairment –presenting visual acuity worse than 6/18 and better than 6/60
☐ Category 2: Severe visual impairment –presenting visual acuity worse than 6/60 and better than 3/60
☐ Category 3: Blindness –presenting visual acuity worse than 3/60 and better than 1/60
☐ Category 4: Blindness—presenting visual acuity worse than 1/60 with light perception
☐ Category 5: Blindness—irreversible blindness with no light perception

SECTION T ▪ Congenital Dislocation of Hip / Congenital Hypertrophic Pyloric Stenosis / Development Dysplasia of the Hip

1. Was there any procedure/surgery performed for the congenital condition?

☐ YES ☐ NO

2. If Yes, kindly provide the Date of Surgery.

☐ Day ☐ Month ☐ Year

3. Specify the type of procedure/surgery done.

4. Name of surgeon and speciality

5. **Enclose copies of all reports, radiological procedures, CT scan, laboratory evidence, other imaging procedure, etc. and any relevant hospital reports that are available.**

SECTION U : 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 :