CRITICAL ILLNESS CLAIM - DOCTOR'S STATEMENT

Eyes and Ears Related Conditions

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/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
☐ Blindness/ Loss of Sight (Both Eyes)	A, B, E & F
☐ Corneal Transplant	A, B, E & F
☐ Loss of Sight in One Eye	A, B, E & F
☐ Bilateral Severe Low Vision	A, B, E & F
☐ Deafness/ Loss of Hearing	A, C, E & F
☐ Cochlea Implant	A, C, E & F
☐ Bilateral Severe Hearing Loss	A, C, E & F
☐ Surgical Drainage for Cavernous Sinus Thrombosis	A, D, E & F

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.

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

- **Blindness/ Loss of Sight (Both Eyes)**
- **Corneal Transplant**
- **Loss of Sight in One Eye**
- **Bilateral Severe Low Vision**

(To be completed by the Opthalmologist)

1. Please provide full and exact details of the injury, disease or condition causing blindness, to include the dates of consultation.

Date of Consultation (DD/MM/YYYY)	Exact Details Causing Blindness

2. Please select (✓) the relevant cause of blindness

☐ Corneal Scarring ☐ Optic Nerve Atrophy ☐ Others. Please specify

3. Were there any associated systemic diseases?

☐ YES ☐ NO

If Yes, please provide details.

4. What is the visual acuity of both eyes at last consultation (using Snellen eye chart or equivalent)?

Last Consultation Date (DD/MM/YYYY)	Visual Acuity		Visual Field	
	Left Eye (Uncorrected):		Left Eye (Uncorrected):	
	Right Eye (Uncorrected):		Right Eye (Uncorrected):	
	Left Eye (Corrected):		Left Eye (Corrected):	
	Right Eye (Corrected):		Right Eye (Corrected):	

5. What forms of treatment were rendered?

6. Is the loss of sight permanent? If Yes, please elaborate?

i. Left Eye ☐ YES ☐ NO

ii. Right Eye ☐ YES ☐ NO

7. Is there any surgery or treatment available that could reinstate vision in either or both eyes? If Yes, please provide information on type of surgery/ treatment.

i. Left Eye ☐ YES ☐ NO

ii. Right Eye ☐ YES ☐ NO

8. Has the patient undergone transplant of a whole cornea or plan to undergo cornea transplant?

☐ YES ☐ NO

If Yes, please provide the surgery date and surgical report.

Day Month Year

9. Is there anything in the patient's habits or personal history which would have increased the risk of blindness?

10. Have any of the patient's family (whether living or dead) suffered from eye disease including blindness, cataract, glaucoma or retinitis pigmentosa?

☐ YES ☐ NO

If Yes, please provide details.

Please attach certified true copied of all relevant reports. (E.g. Radiological, CT scanning, Imaging reports Surgical / procedure reports, Visual acuity tests results Opthalmologist's reports, etc.)

SECTION C ▪ **Deafness/ Loss of Hearing** ▪ **Cochlea Implant** ▪ **Bilateral Severe Hearing Loss**

(To be completed by the ENT Specialist)

1. Please provide full and exact details of the injury, disease or condition causing deafness/loss of hearing, to include the dates of consultation.

Date of Consultation (DD/MM/YYYY)	Exact Details Causing Deafness

2. Is the deafness/ loss of hearing permanent? If Yes, please elaborate?

i. Left Ear ☐ YES ☐ NO

ii. Right Ear ☐ YES ☐ NO

3. What is the degree of hearing loss in all frequency of hearing using a pure tone audiogram or sound-threshold tests in both ears?

4. Is there any surgery or treatment available that could reinstate hearing in either or both ears? If Yes, please provide information on type of surgery/ treatment.

i. Left Ear ☐ YES ☐ NO

ii. Right Ear ☐ YES ☐ NO

5. Has the patient undergone a cochlea implant to correct the hearing loss?

i. Left Ear ☐ YES ☐ NO

ii. Right Ear ☐ YES ☐ NO

If Yes, was the cochlea implant temporary or permanent? Please provide the date of surgery and copy of surgical report.

i. Left Ear ☐ Temporary ☐ Permanent ☐ Day ☐ Month ☐ Year

ii. Right Ear ☐ Temporary ☐ Permanent ☐ Day ☐ Month ☐ Year

6. Was the patient using any hearing aid on the affected ear prior to surgery on cochlea implant?

	Yes/ No	If Yes, please provide the type of hearing aid and duration of usage prior to surgery	
i. Left Ear	☐ YES ☐ NO	Type of hearing aid:	Duration of usage prior to surgery:
ii. Right Ear	☐ YES ☐ NO	Type of hearing aid:	Duration of usage prior to surgery:

7. How was the hearing while the patient was using the hearing aids?

8. Is there anything in patient's habits, personal medical history or occupational hazard which could have increased the risk of loss of hearing .

Please attach certified true copied of all relevant reports. (E.g. Audiometry and sound-threshold tests results certified by an ENT Specialist Surgery report or hospital reports, Radiological, CT scanning, Imaging reports, Blood and laboratory test results, etc.)

SECTION D ▪ **Surgical Drainage for Cavernous Sinus Thrombosis**

1. What was the underlying cause for the Cavernous Sinus Thrombosis?

2. What forms of treatment were rendered?

3. Has the patient undergone surgical drainage of the Cavernous Sinus Thrombosis?

☐ YES ☐ NO

If Yes, please provide the surgery date and copy of surgical report.

☐ Day ☐ Month ☐ Year

Please attach certified true copied of all relevant reports. (E.g. Imaging studies confirming CST eg contrast enhanced CT scan, MR venogram & orbital venography, Surgical Report of the Drainage for Cavernous Sinus Thrombosis Surgery, etc.)

SECTION E : 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 F : 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 :