

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.



Patient's Personal Details

Name		Policy Number	
<input type="text"/>		<input type="text"/>	
NRIC/Old IC/Passport/Birth Cert/Others	Date of Birth	Gender	
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male	<input type="checkbox"/> Female

The claim is being filed for the following illness: (Please tick [✓] in the appropriate box)

Sections to be completed		Sections to be completed	
<input type="checkbox"/> Blindness/ Loss of Sight (Both Eyes)	A, B, E & F	<input type="checkbox"/> Deafness/ Loss of Hearing	A, C, E & F
<input type="checkbox"/> Corneal Transplant	A, B, E & F	<input type="checkbox"/> Cochlea Implant	A, C, E & F
<input type="checkbox"/> Loss of Sight in One Eye	A, B, E & F	<input type="checkbox"/> Bilateral Severe Hearing Loss	A, C, E & F
<input type="checkbox"/> Bilateral Severe Low Vision	A, B, E & F	<input type="checkbox"/> 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
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

FORM ID 11601125

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 Ophthalmologist)

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): <input style="width: 100px;" type="text"/>	Left Eye (Uncorrected): <input style="width: 100px;" type="text"/>
	Right Eye (Uncorrected): <input style="width: 100px;" type="text"/>	Right Eye (Uncorrected): <input style="width: 100px;" type="text"/>
	Left Eye (Corrected): <input style="width: 100px;" type="text"/>	Left Eye (Corrected): <input style="width: 100px;" type="text"/>
	Right Eye (Corrected): <input style="width: 100px;" type="text"/>	Right Eye (Corrected): <input style="width: 100px;" type="text"/>

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 Ophthalmologist's reports, etc.)

SECTION C	<ul style="list-style-type: none"> ▪ Deafness/ Loss of Hearing ▪ Cochlea Implant 	<ul style="list-style-type: none"> ▪ Bilateral Severe Hearing Loss <i>(To be completed by the ENT Specialist)</i>
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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	<input type="checkbox"/> YES <input type="checkbox"/> NO	Type of hearing aid: _____ Duration of usage prior to surgery: _____
ii. Right Ear	<input type="checkbox"/> YES <input type="checkbox"/> 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	
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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 :