Manulife

ATTENDING PHYSICIAN'S STATEMENT
COMA / SEVERE EPILEPSY

A) Patient's Particulars

Name of Patient	Gender
NRIC/FIN or Passport No.	Date of Birth (ddmmyyyy)

B) Patient's Medical Records

1) Please state over what period does the Hospital/Clinic's record extend?

(i) Date of First Consultation (ddmmyyyy)

(ii) Date of Last Consultation (ddmmyyyy)

(iii) Number of consultations during the above period:

(iv) Name of hospital/clinic and Reasons for consultations (with dates):

2) Are you the patient's usual medical doctor? ❒ Yes ❒ No

If "Yes", since when? (ddmmyyyy)

If "No", please provide name and address of the patient's regular doctor.

3) Was the patient referred to you? ❒ Yes ❒ No

If "Yes", please provide:

(i) Date referred (ddmmyyyy)

(ii) Reason the patient was referred:

(iii) Name and address of doctor recommending the referral:

If "No", how did the patient come to consult at your hospital/clinic? (e.g. A&E)

4) Have you referred the patient to any other doctor? ❒ Yes ❒ No

(i) Date referred (ddmmyyyy)

(ii) Reason for referral:

(iii) Name and address of doctor referred to:

5) Does the patient have or ever have had any significant health conditions, medical history or any illness (e.g. tumour, stroke, diabetes, hypertension, hyperlipidaemia, hepatitis, anaemia, etc.)? ❒ Yes ❒ No
If "Yes", please provide:

Details of symptoms	Exact diagnosis	Date diagnosed	Treatment

6) Name and address of doctor whom the patient consulted for the condition(s) stated in Question 5 above.

7) What is your source of the above information?

8) Please give details of the patient's habits in relation to past and present **smoking**, including the duration of smoking habits, number of cigarettes smoked per day and source of this information:

No. of years of smoking	No. of sticks per day	Source of information

9) Please give details of the patient's habits in relation to **alcohol consumption**, including the amount of the alcohol consumption, frequency and the source of this information.

Type of alcohol	Quantity per Consumption	Frequency (per week / month, etc)	Source of information

C) Details of Illness

1) Please provide details of the **Coma** condition:

(i) Date of First consultation for this condition (ddmmyyyy) | | | | | | | | |

(ii) Details of symptom(s) presented during the First consultation, and date these symptoms First started.

(iii) What is the underlying cause(s) of the symptoms?

(iv) Exact Diagnosis of the condition:

ICD-10 Code (if applicable):

(v) Date of First Diagnosis (ddmmyyyy) | | | | | | | | |

(vi) Date the patient first became aware of the illness/condition(ddmmyyyy) | | | | | | | | |

2) Please provide full details and results of all **investigation** (with dates) performed for the diagnosis and **attac**h a copy of all relevant test reports which confirmed the diagnosis.

3) Name and address of the doctor who First diagnosed the patient with this condition.

4) Was the coma a result of an accident, attempted suicide, or self-inflicted act? ❒ Yes ❒ No

If "Yes", please provide full details, and attach a copy of the police report if it was reported to the police.

5) Was the coma resulted from alcohol or drug abuse, or was it a medically induced coma? ❒ Yes ❒ No

If "Yes", please provide full details (e.g. result of blood alcohol concentration, name of drugs, quantity consumed, reasons for the medically induced coma, etc.)

6) Was the coma in any way related or due to congenital anomaly or defect? ❒ Yes ❒ No

If "Yes", please elaborate.

7) How many hours was the patient in a state of coma, with no response to external stimuli? [ ] **hours**

8) Was the patient put on life support measures? ❒ Yes ❒ No

If "Yes", please advise date the patient was put on life support measures and details of such life support measures.

9) Had the patient emerged from the state of coma, with no response to external stimuli? ❒ Yes ❒ No
If "Yes", please state the date and time he/she emerged from the state of coma.

10) Was there any brain damage that resulted in permanent neurological deficit which was assessed thirty (30) days after the onset of the coma? If "Yes", please advise: ❒ Yes ❒ No

(i) Date of the assessment (ddmmyyyy):

(ii) Details of the permanent neurological deficit, and attach a copy of the report(s).

11) Has there been any improvement in the patient's condition since the onset of coma? ❒ Yes ❒ No
Please provide the basis of your evaluation.

12) Is the patient diagnosed with **Epilepsy**? If "Yes", please state: ❒ Yes ❒ No

(i) How was the diagnosis of Epilepsy established?

(ii) Please attach copies of diagnostic reports (i.e. Electroencephalography (EEG), Manetic Resonance Imaging (MRI), Position Emission Tomography (PET) or other test report).

(iii) Has the patient experienced recurrent unprovoked tonic-clonic or grand mal seizures and be known to be resistant to optimal therapy as confirmed by drug serum level testing? ❒ Yes ❒ No
If "Yes", please state:

(a) Dates of Attack:

(b) Frequency of such attacks per week:

(iv) Is the patient taking prescribed anti-epileptic (anti-convulsant) medications recommended by a neurologist? ❒ Yes ❒ No

(v) Would you consider the patient to be an optimal drug therapy? If "Yes", please state the period the patient has been on such anti-epileptic therapy. ❒ Yes ❒ No

D) Other Information

1) What is the prognosis of the patient?

2) Has the patient previously suffered from the conditions leading to the Coma? ❒ Yes ❒ No

If "Yes", please provide details including diagnosed date, exact diagnosis, treatment prescribed, name and address of attending doctor.

3) Is there anything in the patient's **lifestyle** or **personal medical history** which would have increased the risk of this condition? If "Yes", please give details: ❒ Yes ❒ No

Type of Lifestyle / Exact diagnosis	Date of diagnosis	Name of doctor & Address of hospital/clinic

4) Is there anything in the patient's **family history** which would have increased the risk of this condition? If "Yes", please give details: ❒ Yes ❒ No

Relationship with patient	Nature of condition	Age of onset	Source of information

5) Has active treatment and therapy now been rejected in favour of relief of symptoms? If "Yes", please provide full details why this view / course of action is taken. ❒ Yes ❒ No

6) Can you confirm that the advent of death is highly probable within:

(i) six (6) months? ❒ Yes ❒ No

(ii) twelve (12) months? ❒ Yes ❒ No

If "Yes", please describe and provide relevant medical reports that support this view.

7) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for the **Coma or Epilepsy** condition or any other related diseases? If "Yes", please give details:	❒ Yes	❒ No
Name of doctor and Address of hospital/clinic	Date first & last consulted	Reasons for co**n**sultation

8) Please provide us with any other additioanl information that will enable the Company to assess this claim.
9) Please enclose a copy of all reports including specialist or hospital reports, magnetic resonance imaging, computerised tomography or other reliable imaging techniques, laboratory evidence, surgical report, etc. that are available.

E) Declaration

I hereby declare that the above answers are true to the best of my knowledge and belief.

Signature of Doctor	Address & Offical Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	