Manulife

ATTENDING PHYSICIAN'S STATEMENT
ALZHEIMER'S DISEASE / SEVERE DEMENTIA

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, etc.)? If "Yes", please provide: ❒ Yes ❒ No

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 **Alzheimer's Disease / Severe Dementia**:

(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) Name and address of the doctor who **First** diagnosed the patient with Alzheimer's Disease/ Severe Dementia.

3) Please provide full details and results of all **investigation** (with dates) performed for the diagnosis.
And **attach** a copy of all relevant test reports which confirmed the diagnosis. (E.g. brain scans, Mini-mental State Examination (MMSE), Alzheimer's Disease Assessment Scale-Cognitive, etc.

Type of test/assessment	Date of test/assessment	Results of test/assessment

4) Is there evidence of deterioration or loss of intellectual capacity or abnormal behaviour resulting in significant reduction in mental and social functioning? ❒ Yes ❒ No
If "Yes", please describe the findings.

5) Does the patient require **continuous** supervision as a result of the significant reduction in mental and social functioning mentioned in Question 4? ❒ Yes ❒ No
If "Yes", please provide the basis of your evaluation and state the date on which such continuous supervision was first required.

6) Please describe the progression of the patient's Alzheimer's disease/dementia condition since the time he/she was first and last seen at your hospital/clinic (e.g. memory and thinking changes, etc.)

7) How has the patient been coping with the condition during this period of time?

8) Did the deterioration or loss of intellectual capacity or abnormal behaviour arise from:

(i) Non-organic diseases such as neurosis and/or psychiatric illness? ❒ Yes ❒ No

(ii) Head injury related brain damage? ❒ Yes ❒ No

(iii) Alcohol related brain damage? ❒ Yes ❒ No

(iv) Drug abuse? ❒ Yes ❒ No

(v) Any other disease/infections (e.g. HIV-related infections, encephalitis, hypothyroidism, etc.) ❒ Yes ❒ No

If **"Yes"** to any of the above, please elaborate and include date of diagnosis, exact diagnosis, name and address of doctor who made the diagnosis and source of information.

9) Has the patient previously ever suffered from any neurosis or any other psychiatric disorder? ❒ Yes ❒ No

If "Yes", please advise:

Resulting diagnosis	Date of diagnosis	Date first & last consulted	Name of doctor & Address of hospital/clinic

10) Has the patient ever been hospitalised or institutionalised because of any neurosis or psychiatric disorder? If "Yes", please provide details of the stay: ❒ Yes ❒ No

Period of Stay	Reasons for Stay	Treatment received (including operation, if any)	Name of doctor/surgeon & Address of hospital /clinic

11) Was there any memory impairment in the following cognitive areas?

(i) Aphasia (language) ❒ Yes ❒ No

(ii) Apraxia (motor) ❒ Yes ❒ No

(iii) Agnosia (sensory) ❒ Yes ❒ No

(iv) Disturbance in executive functioning (e.g. planning, focus attention, organising, completing tasks) ❒ Yes ❒ No

If "Yes" to any of the above, please elaborate including date of diagnosis, name and address of the neurologist who made the diagnosis and source of information.

12) Please provide details of current **treatment** received for Alzheimer's Disease/Severe Dementia, including the name and dosage of medication, operation contemplated (if any)?

13) Can the condition be controlled with medication? ❒ Yes ❒ No

If "Yes", please state date the medical treatment first started (ddmmyyyy)

14) Are there signs of progressive impairment? ❒ Yes ❒ No

If "Yes", please elaborate (with dates) on how the condition has deteriorated over time.

15) Has the patient previously suffered from the condition(s) specified above or any possible related illnesses or conditions, however minor in nature, which caused the deterioration or loss of intellectual capacity? If "Yes", please provide details: ❒ Yes ❒ No

Exact diagnosis | Date of diagnosis | Name of doctor & Address of hospital/clinic

D) Other Information

1) Is there anything in the patient's **lifestyle** or **personal medical history** which would have increased the patient's risk of suffering from Alzheimer's Disease/Severe Dementia? ❒ Yes ❒ No

If "Yes", please give details:

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

2) Is there anything in the patient's **family history** which would have increased the patient's risk of suffering from Alzheimer's Disease/Severe Dementia? If "Yes", please give details: ❒ Yes ❒ No

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

3) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for the Alzheimer's Disease/Severe Dementia or any other related diseases? ❒ Yes ❒ No

If "Yes", please give details:

Name of doctor and Address of hospital/clinic	Date first & last consulted	Reasons for consultation

4) Has the patient ever been hospitalised for Alzheimer's Disease/Severe Dementia or its related symptoms or complications? If "Yes", please advise: ❒ Yes ❒ No

Date of hospitalisation	Reasons for hospitalisation	Treatment received (including operation, if any)	Name of doctor/surgeon & Address of hospital/clinic

5) Please provide us with any other additional information that will enable the Company to assess the claim.

6) Please enclose a copy of all reports including specialist or hospital reports, magnetic resonance imaging, computed 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)	