

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

<b>A) Patient's Particulars</b>											
Name of Patient	Gender										
NRIC/FIN or Passport No.	Date of Birth (ddmmyyyy)										
	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
<b>B) Patient's Medical Records</b>											
1) Please state over what period does the Hospital/Clinic's record extend?											
(i) Date of First Consultation (ddmmyyyy)	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
(ii) Date of Last Consultation (ddmmyyyy)	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
(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? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>											
If "Yes", since when? (ddmmyyyy)	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
If "No", please provide name and address of the patient's regular doctor.											
3) Was the patient referred to you? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>											
If "Yes", please provide:											
(i) Date referred (ddmmyyyy)	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
(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? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>											
(i) Date referred (ddmmyyyy)	<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
(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.)?  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 **Alzheimer's Disease / Severe Dementia**:

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

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(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)

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

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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:

<u>Resulting diagnosis</u>	<u>Date of diagnosis</u>	<u>Date first &amp; last consulted</u>	<u>Name of doctor &amp; Address of hospital/clinic</u>
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- 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

<u>Period of Stay</u>	<u>Reasons for Stay</u>	<u>Treatment received (including operation, if any)</u>	<u>Name of doctor/surgeon &amp; Address of hospital /clinic</u>
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- 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) 

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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?  Yes  No  
 If "Yes", please provide details:  
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?  Yes  No  
 If "Yes", please give details:  
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? If "Yes", please give details:	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border-bottom: 1px solid black;"><u>Name of doctor and Address of hospital/clinic</u></td> <td style="width: 33%; border-bottom: 1px solid black;"><u>Date first &amp; last consulted</u></td> <td style="width: 33%; border-bottom: 1px solid black;"><u>Reasons for consultation</u></td> </tr> </table>	<u>Name of doctor and Address of hospital/clinic</u>	<u>Date first &amp; last consulted</u>	<u>Reasons for consultation</u>		
<u>Name of doctor and Address of hospital/clinic</u>	<u>Date first &amp; last consulted</u>	<u>Reasons for consultation</u>			
4) Has the patient ever been hospitalised for Alzheimer's Disease/Severe Dementia or its related symptoms or complications? If "Yes", please advise:	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; border-bottom: 1px solid black;"><u>Date of hospitalisation</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Reasons for hospitalisation</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Treatment received (including operation, if any)</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Name of doctor/surgeon &amp; Address of hospital/clinic</u></td> </tr> </table>	<u>Date of hospitalisation</u>	<u>Reasons for hospitalisation</u>	<u>Treatment received (including operation, if any)</u>	<u>Name of doctor/surgeon &amp; Address of hospital/clinic</u>	
<u>Date of hospitalisation</u>	<u>Reasons for hospitalisation</u>	<u>Treatment received (including operation, if any)</u>	<u>Name of doctor/surgeon &amp; Address of hospital/clinic</u>		
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 & Official Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	