Manulife

ATTENDING PHYSICIAN'S STATEMENT
APALLIC SYNDROME

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, hepatitis, diabetes, hypertension, history of accidents/falls, 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 **Apallic Syndrome** condition:

(i) Date the patient First consulted you for this condition (ddmmyyyy)

(ii) Details of symptom(s) presented at 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 describe the cause of the Apallic Syndrome (e.g. brain injury, brain metabolic disorder, central nervous system abnormalities).

3) Please advise the address of the hospital and the name of the consultant neurologist who made the diagnosis of Apallic Syndrome.

4) Please provide dates and details of all investigation performed to establish the **diagnosis** and attach a copy of all relevant investigation Reports (e.g. CT scan, MRI, etc.).

5) Was the condition a result of an **Accident**? ❒ Yes ❒ No

If "No", please proceed to Question 6.

If "Yes", please advise:

(i) Date of Accident (ddmmyyyy)

(ii) Time of Accident (a.m. / p.m.)

(iii) Place of Accident:

(iv) Describe in details how the accident happened.

(v) Describe the extent and severity of the bodily injuries/disability sustained, including exact site(s) of the body.

(vi) Was the accident reported to the police? ❒ Yes ❒ No

If "No", why not?

If "Yes", please provide the following information and **attach** a copy of the police report.

Police Division Name of Police Officer-in-charge

(vii) Was the patient under the influence of alcohol and/or drugs at the time of accident? ❒ Yes ❒ No

If "Yes", please elaborate (e.g. result of blood alcohol concentration, alcohol breath test; name of drugs, quantity consumed, etc.)

(viii) Did the injury result from a self-inflicted act? ❒ Yes ❒ No

If "Yes", please provide full details.

6) Did the patient have any medical condition(s) that had contributed to the accident (e.g. fits)? ❒ Yes ❒ No

If "Yes", please provide full details.

7) Is there presence of universal necrosis of the brain cortex with the brainstem intact? ❒ Yes ❒ No

If "Yes", please provide full details, including the neurological deficit.

8) For how long has the patient been suffering from Apallic Syndrome and its related conditions?

Please attach a copy of the medical documentation.

9) Is the patient's condition expected to improve? ❒ Yes ❒ No

If "Yes", please advise the extent of recovery and the time frame for such recovery to take place.

If "No", please support with evidence.

10) Please provide full details of the treatment received, including the date(s) (e.g. name of medication, type of surgery, therapy etc.).

11) Was the patient hospitalised for the Apallic Syndrome condition or its related symptoms or complications? If "Yes", please provide full details. ❒ Yes ❒ No

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

12) Is the patient still on follow-up at your hospital / clinic? ❒ Yes ❒ No

If "Yes", please advise date of next appointment (ddmmyyyy) | | | | | | | | |

If "No", please state date of discharge (ddmmyyyy) | | | | | | | | |

D) Other Information

1) What is the prognosis of the patient's condition?

2) Please describe and elaborate on the nature and severity of the patient's **physcial** and **mental** disability and limitation when you last saw him/her.

3) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for **Apallic Syndrome, or any possible related illness**, especially any consultations concerning neurological symptoms or complaints? If "Yes", please give details: ❒ Yes ❒ No

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

4) Is there anything in the patient's **personal medical history** or **family history** which would have increased the risk of the Apallic Syndrome and/or its related illness? If "Yes", please give details: ❒ Yes ❒ No

Exact diagnosis	Date of diagnosis	Name of doctor & address of hospital/clinic

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? (ii) twelve (12) months? If "Yes", please describe and provide relevant medical reports that support this view.	❒ Yes ❒ No ❒ Yes ❒ No
7) Please provide us with any other additioanl information that will enable the Company to assess this claim.	
8) Please enclose a copy of all reports including specialist or hospital reports, laboratory evidence, magnetic resonace image, computed tomography, 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)	