Manulife

ATTENDING PHYSICIAN'S STATEMENT
APLASTIC ANAEMIA

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. cyst, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, blood transfusion, 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 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 **Aplastic Anaemia**:

(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) Name and address of the **haematologist** who **First** diagnosed the patient with Aplastic Anaemia.

3) Please provide details of **investigation** performed (with dates) to establish the diagnosis of Aplastic Anaemia (e.g. bone marrow aspirate and biopsy, X-ray, computed tomography scans, ultrasound imaging tests, laboratory tests including antibodies, complete blood count, liver function tests, etc.). Also, please **attach** a copy of all the relevant test reports.

4) What is the likely cause of the patient's Aplastic Anaemia, if known (e.g. exposure to drugs, infection, autoimmune disease, heredity)?

5) Is the patient's condition in any way attributable to Human Immunodeficiency virus (HIV) infection or Acquired Immune Deficiency Syndrome (AIDS)? If "Yes", please provide details. ❒ Yes ❒ No

6) Was the patient's Aplastic Anaemia due to:

(i) Acute reversible bone marrow failure? ❒ Yes ❒ No

(ii) Chronic persistent bone marrow failure? ❒ Yes ❒ No

7) Was there:

(i) Anaemia? ❒ Yes ❒ No

(ii) Neutropenia? ❒ Yes ❒ No

(iii) Thrombocytopenia? ❒ Yes ❒ No

8) Does the patient require or has received the following treatment:

(i) Blood product transfusion? ❒ Yes ❒ No

(ii) Marrow stimulating agents? ❒ Yes ❒ No

(iii) Immunosuppressive agents? ❒ Yes ❒ No

(iv) Bone marrow transplantation? ❒ Yes ❒ No

9) Please provide details of treatment administered, including date/period of treatment, name and address of attending doctors.

10) Has the patient ever been hospitalised for Aplastic Anaemia or its related symptoms or complications? ❒ Yes ❒ No

If "Yes", please advise:

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

D) Other Information

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

2) Is there anything in the patient's **personal medical history** which would have increased the risk of Aplastic Anaemia? If "Yes", please give details: ❒ Yes ❒ No

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

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

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

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

5) 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.

6) Please describe and elaborate on the nature and severity of the patient's **physical** and **mental** disability and limitation, if any.

7) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for **Aplastic Anaemia or any possible related illness**? If "Yes", please give details: ❒ Yes ❒ No

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

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, bone marrow aspirate and biopsy, computed tomography scans, ultrasound imaging tests, laboratory tests including antibodies, complete blood count, liver function tests, 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)	