Manulife

ATTENDING PHYSICIAN'S STATEMENT
DEAFNESS (LOSS OF HEARING) /
CAVERNOUS SINUS THROMBOSIS SURGERY or COCHLEAR IMPLANT SURGERY

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 Reason 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, 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 **Deafness (Loss of Hearing)** condition:

(i) Date the patient First consulted you 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 dates and details of investigation performed for the diagnosis and attach a copy of all relevant test reports (including audiometric and sound-threshold tests) which confirmed the diagnosis.

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

4) Is there total loss of hearing in both the ears? If "Yes", please state: ❒ Yes ❒ No

(i) The current hearing ability in both ears (in decibels):

Right Ear _____ Left Ear _____

(ii) Please provide copies of audiogram and sound-threshold tests.

5) Is there a total loss of at least 80 decibels in all frequencies of hearing in both ears? ❒ Yes ❒ No

If "Yes", please provide supporting evidence (including audiometric and sound-threshold tests results).

6) Is the hearing loss irreversible in both ears? ❒ Yes ❒ No

7) Is there any surgery available that could reinstate hearing in either or both ears? ❒ Yes ❒ No

If "Yes", please state:

(i) Nature of surgery:

(ii) What is the best possible corrected hearing frequency for both ears?

Right Ear _____ Left Ear _____

(iii) Has such surgery been recommended to the patient? ❒ Yes ❒ No

(iv) Tentative Date of Surgery (ddmmyyyy) | | | | | | | | |

8) Is the condition resulting from drug induced partial hearing loss? ❒ Yes ❒ No

If "Yes", please provide details.

9) Has the patient undergone **surgery for Cavemous Sinus Thrombosis**? ❒ Yes ❒ No
If "No", please proceeds to **Question 10.**
If "Yes", please advise the following:

(i) Date of diagnosis of Cavermous Sinus Thrombosis (ddmmyyyy) | | | | | | | | |

(ii) Was the surgery perfromed for Cavermous Sinus Thrombosis? If "Yes", please state: ❒ Yes ❒ No

(a) Type of Surgery performed:

(b) Date of Surgery was performed (ddmmyyyy) | | | | | | | | |

(c) Please attach copies of Operation Report and diagnostic test report.

10) Has the patient undergone **Cochlear Implant Surgery**? ❒ Yes ❒ No
If "No", please proceeds to **Section D.**
If "Yes", please advise the following:

(i) Was there permanent damange to the cochlea or auditory nerve? ❒ Yes ❒ No

(ii) Was a Cochlear Implant Surgery performed? If "Yes", please state ❒ Yes ❒ No

(a) Date it was performed (ddmmyyyy) | | | | | | | | |

(b) Please attach copies of Operation Report.

(c) Was the surgery performed considered medically necessary by the ENT Specialist? ❒ Yes ❒ No

D) Other Information

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

2) Is the loss of hearing in any way related or due to congenital anomaly or defect? ❒ Yes ❒ No
If "Yes", please provide details including date of diagnosis.

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

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 Loss of Hearing? ❒ Yes ❒ No

If "Yes", please give details:

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

5) Please describe and elaborate on the nature and severity of the patient's disability and limitation, if any.

6) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for **Ear 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 consultation

7) Please enclose copies of all reports including specialist or hospital reports, audiogram and sound-threshold tests, Cerebral Angiopgraphy, CT scans, MRI, other imaging stdies, 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)	