Manulife

ATTENDING PHYSICIAN'S STATEMENT
ENCEPHALITIS

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, hyperlipidaemia, 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 **Encephalitis**:

(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) Is the Encephalitis caused by viral infection? ❒ Yes ❒ No

If "No", please state the underlying cause of the condition.

3) Is there severe inflammation of the brain substance (cerebral hemisphere, brainstem or cerebellum)? ❒ Yes ❒ No

4) Please describe in full details (with dates) the extent of neurological deficits.

5) Do the neurological deficits (described in Question 4) last for a **continuous** period of at least six (6) weeks? ❒ Yes ❒ No

6) Are the neurological deficits/damages irreversible and permanent? ❒ Yes ❒ No

(i) If "Yes", please elaborate with supporting evidence.

(ii) If "No", please state date of recovery *or* date for which the patient is likely to recover from these neurological deficits:

7) Please provide details of **investigation** performed, with dates (e.g. Brain MRI, culture of cerebrospinal fluid (CSF), electroencephalogram).
Also, please **attach** a copy of all the relevant test reports.

8) Name and address of the **neurologist** who **First** diagnosed the patient with Encephalitis.

9) Please provide details of current **treatment**, including any physical and speech therapy, if any.

10) Is the Encephalitis caused by HIV infection? ❒ Yes ❒ No
If "Yes", please provide details including date of diagnosis of HIV infection, name and address of doctor who made the diagnosis.

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 Encephalitis? If "Yes", please give details: ❒ Yes ❒ No

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

3) Please describe and elaborate on the nature and severity of the patient's **physical** and **mental** disability and limitation (e.g. loss of memory, muscle control, speech, vision, etc.).

4) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for **Encephalitis or any possible related illness**, especially any consultations concerning neruological 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

5) Has the patient ever been hospitalised for Encephalitis 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

6) Please provide us with any other additioanl information that will enable the Company to assess this claim.

7) Please enclose a copy of all reports including specialist or hospital reports, cerebrospinal fluid analysis result, laboratory evidence, 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)	