

**ATTENDING PHYSICIAN'S STATEMENT
MOTOR NEURONE DISEASE**

A) Patient's Particulars											
Name of Patient	Gender										
NRIC/FIN or Passport No.	Date of Birth (ddmmyyyy)										
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B) Patient's Medical Records											
1) Please state over what period does the Hospital/Clinic's record extend?											
(i) Date of first consultation (ddmmyyyy)	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>										
(ii) Date of last consultation (ddmmyyyy)	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></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? <input type="checkbox"/> Yes <input type="checkbox"/> No											
If "Yes", since when? (ddmmyyyy)	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>										
If "No", please provide name and address of the patient's regular doctor.											
3) Was the patient referred to you? <input type="checkbox"/> Yes <input type="checkbox"/> No											
If "Yes", please provide:											
(i) Date referred (ddmmyyyy)	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></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? <input type="checkbox"/> Yes <input type="checkbox"/> No											
(i) Date referred (ddmmyyyy)	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></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, 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 **Motor Neurone Disease**:

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

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(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 (including type of motor neurone disease, e.g. Amyotrophic lateral sclerosis, progressive bulbar palsy, etc.):

ICD-10 Code (if applicable):

(v) Date of First diagnosis (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> </tr> </table>								
(vi) Date the patient First became aware of the condition: (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> </tr> </table>								
2) Name and address of the Neurologist who First diagnosed the patient of Motor Neurone Disease.									
3) Please provide the details of all investigations performed to establish the diagnosis (e.g. electromyogram, nerve conduction studies, brain and spinal cord MRI, etc.)?									
<u>Name of Investigation</u>	<u>Date of Investigation</u>								
<u>Results of Investigation</u>									
Please attach a copy of the above investigation reports.									
4) Please describe in full details (with dates) the extent of neurological deficit.									
5) Are the neurological deficit (mentioned in Question 4):									
(i) Progressive?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(ii) Permanent?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
(a) If "Yes", please elaborate with supporting evidence.									
(b) If "No", please state date of recovery <i>or</i> date for which the patient is likely to recover from these neurological deficits: (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> </tr> </table>								
6) Please provide details of current treatment .									
7) Is the patient still on follow-up at your hospital / clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No									
If "Yes", please advise date of next appointment (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> </tr> </table>								
If "No", please state date of discharge (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> </tr> </table>								

D) Other Information			
1) What is the prognosis of the patient's condition?			
2) Has the patient previously suffered from the abovementioned condition(s) and/or any related illness, however minor in nature, concerning neurological symptoms or complaints? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes", please give details:			
<u>Name of doctor and Address of hospital/clinic</u>	<u>Date of first & last consultation</u>	<u>Diagnosis</u>	
3) Has the patient ever been hospitalised for Motor Neurone Disease and/or its related symptoms or complications? If "Yes", please advise: <input type="checkbox"/> Yes <input type="checkbox"/> No			
<u>Date of hospitalisation</u>	<u>Reasons for hospitalisation</u>	<u>Treatment received (including operation, if any)</u>	<u>Name of doctor/surgeon & Address of hospital</u>
4) Is there anything in the patient's personal medical history or family history which would have increased the risk of the Motor Neurone Disease or its related illness? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes", please give details:			
<u>Exact diagnosis</u>	<u>Date of diagnosis</u>	<u>Name of doctor & address of hospital/clinic</u>	
5) Please describe the nature and severity of the patient's physical and mental disability and limitation, if any.			

6) 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.

7) 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.

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

9) Please enclose a copy of all reports including specialist or hospital reports, lelectromyogram, nerve conduction studies, MRI – brain and/or spincal cord, 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)	