Manulife

ATTENDING PHYSICIAN'S STATEMENT
STROKE / BRAIN ANEURYSM SURGERY OR CEREBRAL SHUNT INSERTION / CAROTID ARTERY 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 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, 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 **Stroke**:

(i) Date of first consultation 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 which confirmed the diagnosis.

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

4) Please describe the initial episode:

(i) Nature of episode:

(ii) Date of initial episode (ddmmyyyy)

(iii) Duration of acute symptoms:

5) Was there any neurological deficit lasting for at least six (6) weeks after the initial episode of Stroke? ❒ Yes ❒ No

If "Yes",

(i) Please describe the neurological deficit.

(ii) Please describe the symptoms of dysfunction in the nervous system that are present on clinical examination.

(iii) How long have these sequelae been present since the initial episode?

(iv) Is the neurological deficit with its clinical symptoms likely to be **permanent, lasting throughout the lifetime** of the patient? Please elaborate with supporting evidence. ❒ Yes ❒ No

6) Has there been an infarction of brain tissue, haemorrhage, embolism and thrombosis from an extracranial souce? If "Yes", please provide full details. ❒ Yes ❒ No

7) Are the investigations or findings consistent with the diagnosis of a new Stroke? ❒ Yes ❒ No

If "Yes", please provide details and attach a copy of all reports, CT Scan, MRI, laboratory test results, etc.

8) Please provide details of the surgery and/or other mode of treatment that had been performed, including type and date of treatment, and name and address of attending specialist.

9) Please confirm the following:

(i) Is this a Transient Ischaemic Attack? ❒ Yes ❒ No

(ii) Was the brain damaged due to an accident or injury, infection, vasculities, and inflammatory disease? ❒ Yes ❒ No

(iii) Was this condition due to vascular disease effecting the eye or optic nerve? ❒ Yes ❒ No

(iv) Was this condition due to ischaemic disorder of the vestibular system? ❒ Yes ❒ No

10. Has the patient undergone any **Brain Aneurysm Surgery**? ❒ Yes ❒ No

If "No", please proceeds to **Question 11**.

If "Yes", please proceeds as follow:

(i) Was an arteriogram / cerebral angiogram carried out? If "Yes", please advise: ❒ Yes ❒ No

(ii) Date of arteriogram performed (ddmmyyyy)

Please attach a copy of the report.

(iii) Was surgery carried out to correct intracranial aneurysm or arterio-venous malformation? ❒ Yes ❒ No

If "Yes", please advise:

(iv) Date of surgery (ddmmyyy)

(v) Nature of surgery

(vi) Was surgery done via craniotomy? ❒ Yes ❒ No

If "No", please state the type of surgery performed.

(vii) Please attach a copy of the tomography (CT) scan, magnetic resonance imagin (MRI), magnetic resonance angiograph (MRA) or angiogram.

11. Has the patient undergone any **Cerebral Shunt Insertion**? ❒ Yes ❒ No

If "No", please proceeds to **Question 12**.

If "Yes", please advise:

(i) How was this diagnosis established? Please include a copy of diagnostic investigation report.

(ii) Is the patient's condition of hydrocephalus congenital in nature? ❒ Yes ❒ No

If "No", please indicate the cause of hydrocephalus.

(iii) Was there any intracranial pressure giving rise to neurological deficit as a result of hydrocephalus? If "Yes", please indicate the neurological deficit(s). ❒ Yes ❒ No

(iv) Was there surgical implantation of a shunt from the ventricles of the brain? ❒ Yes ❒ No

If "Yes", please state:

(v) Date of shun insertion (ddmmyyyy) | | | | | | | | |

(vi) Was the surgery performed considered medically necessary by the consultant neurosurgeon? ❒ Yes ❒ No

(vii) Is there other mode of treatment other than shunt insertion, which could have been used to treat the patient's hydrocephalus? If "Yes", please state the nature of treatment and why this treatment was not used. ❒ Yes ❒ No

12. Did the patient suffer from **narrowing of the Carotid Artery**? ❒ Yes ❒ No

If "No", please proceeds to **Section D**.

If "Yes", please advise:

(i) Was an arteriography carried out? If "Yes", please provide a copy of report. ❒ Yes ❒ No

(ii) Please state the percentage of narrowing of the carotid artery. | | %

(iii) Was Endarterectomy carried out to correct the carotid artery? ❒ Yes ❒ No

If "Yes", please state the date of surgery (ddmmyyyy) | | | | | | | | |

If "No", please state the type of treatment provided.

D) Other Information

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

2) Is the patient's condition or surgery performed in any way related or due to:

(i) AIDS or HIV related illness? ❒ Yes ❒ No

(ii) Use of drug not prescribed by a registered medical practitioner or drug abuse/ ❒ Yes ❒ No

(iii) Alcohol abuse / misuse? ❒ Yes ❒ No

(iv) Congenital or inherited disorder? ❒ Yes ❒ No

(v) Attempted suicide or self-inflicted injuries? ❒ Yes ❒ No

If "Yes" for (i) to (v), please provide details and enclsoe a copy of the test result.

(a) Date of diagnosis (ddmmyyyy)

(b) Exact diagnosis

(c) Name and address of doctor who first diagnosed the patient with the condition.

3) Is there anything in the patient's **personal medical history** which would have increased the risk of Stroke, intracranial aneurysm, arterio-venous malformation, hydrocephalus or narrowing of carotid artery or any related illness (e.g. hypertension, transient ischaemic attack, angina, other cardiovascular disease, congenital anomaly or defect, etc)? If "Yes", please give etails: ❒ 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 Stroke? If "Yes", please give details: ❒ Yes ❒ No

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

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 Stroke or any other related diseases? If "Yes", please give details: ❒ Yes ❒ No

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

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

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

If "No", please state date of discharge (ddmmyyyy), if any.

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

10) Please enclose a copy of all specialist or hospital reports, including magnetic resonance imaging, computerised tomography, or any reliable imagining technques, laboratory test results, 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)	