Manulife

ATTENDING PHYSICIAN'S STATEMENT (POSTPARTUM PSYCHOSIS)

Policy No.
Claim No. (For internal use)

To be completed by the Attending Physician at Insured's expense.

1. PATIENT'S PARTICULARS

Name of the Patient: _____ NRIC/Passport No: _____

Date of Birth: _____ Sex: _____ Admission No: _____ Ward No: _____

Date of Admission: _____ Date of Discharge: _____

2. DETAILS OF PATIENT'S CONDITION

In order for a claim under this policy to be paid, the following definition must be satisfied:

Postpartum Psychosis means a mental state directly caused by childbirth and is characterised by loss of insight, paranoia, nightmares, hallucinations and thoughts of harming herself or her baby. The life insured is required to be confined in a hospital or psychiatric clinic for psychiatric treatment.

(a) Please describe the exact details of the patient's condition.

_____

_____

_____

_____

(b) Date you were first consulted for the condition: _____/ _____/ _____
dd mm yyyy

(c) What are the signs or symptoms presented at that time?

Signs or Symptoms presented at that time		Date first appeared
Loss of insight	☐	_____
Paranoia	☐	_____
Nightmares	☐	_____
Hallucinations	☐	_____
Thoughts of harming herself or baby	☐	_____
Others (please specify): _____		_____
_____		_____
_____		_____

Manulife (Singapore) Pte Ltd.
Reg. No. 198002116D
Main Office: 8 Cross Street #15-01, Manulife Tower, Singapore 048424
Tel: 67371221 Website: www.manulife.com.sg

(d) Date when the condition was first diagnosed: _____/ _____/ _____
dd mm yyyy

(e) Date when your patient first became aware of this condition: _____/ _____/ _____
dd mm yyyy

(f) Has the patient suffered any previous episodes of the underlying condition or any other condition leading to or relating to it? If yes, please give details. □ Yes □ No

_____
_____
_____
_____

(g) Are you aware of any members of the patient's close family who have suffered from this condition or any congenital disease? If yes, please give details. □ Yes □ No

_____
_____
_____

(h) Please confirm the diagnosis of Postpartum Psychosis as described above.

_____
_____
_____

(i) Date of delivery: _____/ _____/ _____
dd mm yyyy

(j) What is the patient's current mental state?

_____
_____

(k) Is treatment continuing at present? If yes, please give details. □ Yes □ No

_____
_____
_____

(l) Please give full details of all investigations performed in relation to this condition and their results.

_____
_____
_____
_____

(m) Please give the name and address of the doctor who has confirmed the diagnosis of Postpartum Pyschosis.

_____
_____

3. MEDICAL HISTORY

(a) If the patient was referred from a clinic or hospital, please state:

(i) Name of referral doctor: _____

(ii) Name of clinic/ hospital: _____

(iii) Date referred: _____

(b) Did the patient consult other doctors for this illness or its symptoms before she consulted you?

□ Yes □ No

If yes, please provide the name(s) and address(es) of the doctor(s) whom she consulted.

Name of Doctor	Name of Clinic/ Hospital and Address	Dates of Consultation

(c) Was the patient previously hospitalised for this condition? □ Yes □ No

If yes, please give details.

Name & Address of Hospital	Period (s) of Hospitalisation	
	From	To

(d) Is the patient suffering or has suffered from any other significant illnesses? □ Yes □ No

If yes, please provide the following information to us.

Illness	Date of first Diagnosis	Name and Address of Attending Doctor

(e) Did you refer the patient to any other doctor(s)? □ Yes □ No

If yes, please provide the name and address of the doctor(s).

Name of Doctor	Address

(f) Are you the patient's regular doctor? □ Yes □ No

If yes, since when? _____/ _____/ _____
dd mm yyyy

If no, please provide the name and address of the patient's regular doctor.

_____

_____

(g) Please give any other information which you feel would be helpful in assessment of the patient's claim.

_____

_____

_____

_____

Please enclose copies of specialist or hospital reports together with any tests or similar evidence to support the validity of the patient's claim.

Signature of Doctor

Date

Address & Official Stamp

Name and Qualification (printed)

Manulife (Singapore) Pte Ltd.
Reg. No. 198002116D
Main Office: 8 Cross Street #15-01, Manulife Tower, Singapore 048424
Tel: 67371221 Website: www.manulife.com.sg