

**ATTENDING PHYSICIAN'S STATEMENT
APLASTIC ANAEMIA**

A) Patient's Particulars									
Name of Patient	Gender								
NRIC/FIN or Passport No.	Date of Birth (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>								

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):	<table border="1" style="width: 100%; height: 40px; 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> <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) Are you the patient's usual medical doctor? If "Yes", since when? (ddmmyyyy) If "No", please provide name and address of the patient's regular doctor.	<input type="checkbox"/> Yes <input type="checkbox"/> No <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>								

3) Was the patient referred to you? 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.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <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>								

4) Have you referred the patient to any other doctor? (i) Date referred (ddmmyyyy) (ii) Reason for referral: (iii) Name and address of doctor referred to:	<input type="checkbox"/> Yes <input type="checkbox"/> No <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>								

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, blood transfusion, etc.)? If "Yes", please provide: <u>Details of symptoms</u> <u>Exact diagnosis</u> <u>Date diagnosed</u> <u>Treatment</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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: <div style="display: flex; justify-content: space-around;"> <u>No. of years of smoking</u> <u>No. of sticks per day</u> <u>Source of information</u> </div>	
9) Please give details of the patient's habits in relation to alcohol consumption , including the amount of the alcohol consumption, frequency and source of this information: <div style="display: flex; justify-content: space-around;"> <u>Type of alcohol</u> <u>Quantity per consumption</u> <u>Frequency (per week / month, etc.)</u> <u>Source of information</u> </div>	

C) Details of Illness											
1) Please provide details of Aplastic Anaemia :											
(i) Date the patient First consulted you for this 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> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
(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)	<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> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
(vi) Date the patient First became aware of the illness/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> <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) Is there anything in the patient's personal medical history which would have increased the risk of Aplastic Anaemia? If "Yes", please give details:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Exact diagnosis</u>	<u>Date of diagnosis</u> <u>Name of doctor & address of hospital/clinic</u>
3) Is there anything in the patient's family history which would have increased the risk of Aplastic Anaemia? If "Yes", please give details:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Relationship with patient</u>	<u>Nature of condition</u> <u>Age of onset</u> <u>Source of information</u>
4) Has active treatment and therapy now been rejected in favour of relief of symptoms? If "Yes", please provide full details why this view / course of action is taken.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5) Can you confirm that the advent of death is highly probable within: (i) six (6) months? (ii) twelve (12) months? If "Yes", please describe and provide relevant medical reports that support this view.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
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 Aplastic Anaemia or any possible related illness ? If "Yes", please give details:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Name of doctor and Address of hospital/clinic</u>	<u>Date of first & last consultation</u> <u>Reasons for consultation</u>

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, bone marrow aspirate and biopsy, computed tomography scans, ultrasound imaging tests, laboratory tests including antibodies, complete blood count, liver function tests, 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 & Official Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	