

**ATTENDING PHYSICIAN'S STATEMENT
BACTERIAL MENINGITIS**

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)	<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>								
(ii) Date of last consultation (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>								
(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="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 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="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>								
(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="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>								
(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. brain herniation, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, etc.)? If "Yes", please provide: Yes No
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 **Bacterial Meningitis**:

--	--	--	--	--	--	--	--	--	--

(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 there severe inflammation of the membranes of the brain or spinal cord?	<input type="checkbox"/> Yes <input type="checkbox"/> No										
3) Please describe in full details (with dates) the extent of neurological deficits.											
4) Do the neurological deficits (described in Question 3) last for a continuous period of at least six (6) weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No										
5) Are the neurological deficits/damages irreversible and permanent?											
(i) If "Yes", please elaborate with supporting evidence.											
(ii) If "No", please state date of recovery <i>or</i> date for which the patient is likely to recover from these neurological deficits:											
	<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>										
6) Please provide details of investigation performed (with dates) on the cerebrospinal fluid and blood culture, stating the types of organism found in each. Also, please attach a copy of all the relevant test reports.											
7) What was the cerebrospinal fluid collection method?											
8) Name and address of the neurologist who First diagnosed the patient with Bacterial Meningitis.											
9) Please provide details of current treatment , including name and dosage of medication, operation contemplated (if any).											

10) Is the patient HIV positive?

Yes No

If "Yes", please provide details including date of diagnosis, name and address of the doctor who first 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 Bacterial Meningitis? If "Yes", please give details:

Yes No

Exact diagnosis

Date of diagnosis

Name of doctor & address of hospital/clinic

3) Is there anything in the patient's **family history** which would have increased the risk of Bacterial Meningitis? If "Yes", please give details:

Yes No

Relationship with patient

Nature of condition

Age of onset

Source of information

4) Please describe and elaborate on the nature and severity of the patient's **physical** and **mental** disability and limitation (e.g. brain damage, hearing loss, learning disabilities), if any.

5) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for Bacteria Meningitis or any possible related illness , especially any consultations 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>Reasons for consultation</u>	
6) Has the patient ever been hospitalised for Bacterial Meningitis 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>	
7) Please provide us with any other additional information that will enable the Company to assess this claim.	
8) 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 & Official Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	