

**ATTENDING PHYSICIAN'S STATEMENT
BENIGN BRAIN TUMOUR / SURGICAL REMOVAL OF PITUITARY TUMOUR OR
SURGERY FOR SUBDURAL HAEMATOMA**

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. cyst, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, anaemia, etc) If "Yes", please provide:	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; border-bottom: 1px solid black;"><u>Details of symptoms</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Exact diagnosis</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Date diagnosed</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Treatment</u></td> </tr> </table>	<u>Details of symptoms</u>	<u>Exact diagnosis</u>	<u>Date diagnosed</u>	<u>Treatment</u>	
<u>Details of symptoms</u>	<u>Exact diagnosis</u>	<u>Date diagnosed</u>	<u>Treatment</u>		
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:					
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border-bottom: 1px solid black;"><u>No. of years of smoking</u></td> <td style="width: 33%; border-bottom: 1px solid black;"><u>No. of sticks per day</u></td> <td style="width: 34%; border-bottom: 1px solid black;"><u>Source of information</u></td> </tr> </table>	<u>No. of years of smoking</u>	<u>No. of sticks per day</u>	<u>Source of information</u>		
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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.					
<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; border-bottom: 1px solid black;"><u>Type of alcohol</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Quantity per Consumption</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Frequency (per week / month, etc)</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Source of information</u></td> </tr> </table>	<u>Type of alcohol</u>	<u>Quantity per Consumption</u>	<u>Frequency (per week / month, etc)</u>	<u>Source of information</u>	
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C) Details of Illness											
1) Please provide details of Benign Brain Tumour condition:											
(i) Date of First consultation for this condition (ddmmyyyy)	<table border="1" style="border-collapse: collapse; width: 100%;"> <tr> <td style="width: 12.5%; height: 20px;"></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 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)	<table border="1" style="border-collapse: collapse; width: 100%;"> <tr> <td style="width: 12.5%; height: 20px;"></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="border-collapse: collapse; width: 100%;"> <tr> <td style="width: 12.5%; height: 20px;"></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>										

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) Has the tumour caused an increase in the intracranial pressure? Yes No
 If "Yes", please provide details of the life threatening condition and/or neurological deficits suffered.

5) Please answer the following questions with regard to the **Benign Brain tumour**.
 (If "Yes" to any question, please elaborate with supporting evidence such as magnetic resonance imaging, computerised tomography, or other reliable imaging techniques.)

(i) Is it life threatening? Yes No

(ii) Has it caused damage to the brain? Yes No

(iii) Has it been surgically removed? Yes No
 If "Yes", please state:
 (a) Type of Surgery:

(b) Date of Surgery (ddmmyyyy)

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(c) Tumour has been totally or partially removed? (Please tick) Totally removed Partially removed

(d) Details of histology:

(iv) If the tumour is inoperable, has it caused any neurological deficits? Yes No
 If "Yes", please state:
 (a) Details of the neurological deficits suffered:

(b) Are the neurological deficits permanent? Yes No

6) Is the patient's condition a cyst, a granuloma, vascular malformation in or of the arteries of the brain or haematomas? If "Yes", please state the type. Yes No

7) Is the patient's tumour of the pituitary or spinal cord? If "Yes", please state the type. Yes No

8) Has the patient undergone **surgery for Subdural Hematoma**? Yes No
 If "No", please proceed to **Section D**.
 If "Yes", please advise the following:

(i) Was the cause of subdural hematoma a result of an accident? Yes No
 If "Yes", please state Date of Accident (ddmmyyyy)

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 Please provide details of how the accident occurred.

(ii) What were the investigations done to establish the diagnosis of subdural Hematoma? Please provide a copy of diagnostic reports (i.e. Magnetic Resonance Imaging (MRI), Computerised Tomography (CT) or others.)

(iii) Was the subdural hematoma drained through a Burr Hole Surgery to the head? Yes No
 If "No", please state the treatment provided.

D) Other Information

1) Has the patient previously suffered from **Benign Brain Tumour** or any **related illness**? Yes No
 If "Yes", please provide details including date of diagnosis, exact diagnosis, treatment prescribed, name and address of attending doctor.

2) Is there anything in the patient's **personal medical history** which would have increased the risk of this condition? 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 this condition? If "Yes", please give details:	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; border-bottom: 1px solid black;"><u>Relationship with patient</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Nature of condition</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Age of onset</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Source of information</u></td> </tr> </table>	<u>Relationship with patient</u>	<u>Nature of condition</u>	<u>Age of onset</u>	<u>Source of information</u>	
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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?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
(ii) twelve (12) months?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 disability and limitation, if any.					
7) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for the condition or any other related diseases? If "Yes", please give details:	<input type="checkbox"/> Yes <input type="checkbox"/> No				
<table style="width: 100%; border: none;"> <tr> <td style="width: 45%; border-bottom: 1px solid black;"><u>Name of doctor and Address of hospital/clinic</u></td> <td style="width: 25%; border-bottom: 1px solid black;"><u>Date first & last consulted</u></td> <td style="width: 30%; border-bottom: 1px solid black;"><u>Reasons for consultation</u></td> </tr> </table>	<u>Name of doctor and Address of hospital/clinic</u>	<u>Date first & last consulted</u>	<u>Reasons for consultation</u>		
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8) Please enclose a copy of all reports including specialist or hospital reports, magnetic resonance imaging, computerised tomography or other reliable imaging techniques, biopsy reports, cytology reports, histology reports, 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 & Official Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	