

**ATTENDING PHYSICIAN'S STATEMENT
BLINDNESS (LOSS OF SIGHT) / OPTIC NERVE ATROPHY WITH LOW VISION**

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. glaucoma, 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 **Blindness (Loss of Sight)** condition:

(i) Date the patient First consulted you for this condition (ddmmyyyy)

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(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)

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(vi) Date the patient first became aware of the illness/condition(ddmmyyyy)

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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) What is the current visual acuity of both eyes using Snellen eye chart:

Right Eye

Left Eye

5) What is the current visual field in both eyes?

Right Eye

Left Eye

6) Is there any surgery available that could reinstate vision in either or both eyes? Yes No

If "Yes", please state:

(i) Nature of surgery:

(ii) What is the best possible corrected visual acuity of both eyes:

Right Eye

Left Eye

(iii) Has such surgery been recommended to the patient? Yes No

If "No", why not?

(iv) Tentative Date of Surgery (ddmmyyyy)

7) Has the patient suffered from **Optic Nerve Atrophy with low vision**? Yes No

If "No", please proceed to **Question 8**.

If "Yes", please advise the following.

(i) How was the diagnosis of optic nerve atrophy established?

(ii) Are both eyes affected as a result of optic nerve atrophy? Yes No

If "Yes", please provide details.

(iii) What is the best corrected visual acuity of both eyes, at present, using the Snellen eye chart?

Right Eye

Left Eye

8) Is the visual loss permanent and irreversible in one or both eyes? Yes No

If "Yes", please indicate which eye is affected, and provide relevant medical reports that support this view.

9) Is the condition resulting from alcohol and/or drug misuse? Yes No

If "Yes", please provide details.

10) Is the blindness in any way related or due to congenital anomaly or defect? Yes No

If "Yes", please provide details including date of 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 **Blindness**? If "Yes", please give details: Yes No

Exact diagnosis Date of diagnosis Name of doctor & Address of hospital/clinic

3) Has any of the patient's **family members** suffered from eye disease including blindness, cataract, Yes No or retinitis pigmentosa, etc.? If "Yes", please give details:

Relationship with patient Nature of illness Date of diagnosis Source of information

4) Please describe and elaborate on the nature and severity of the patient's disability and limitation, if any.

5) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for eye disease or any other related diseases? If "Yes", please give details:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
<table style="width: 100%; border-collapse: collapse;"> <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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6) Please provide us with any other additional information that will enable the Company to assess this claim.				
7) Please enclose copies of all reports including specialist (ophthalmologist) or hospital reports, CT scans, other imaging studies, 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)				