Manulife

ATTENDING PHYSICIAN'S STATEMENT
HIV DUE TO BLOOD TRANSFUSION, ASSAULT, ORGAN TRANSPLANT AND OCCUPATIONALLY ACQUIRED HIV

A) Patient's Particulars

Name of Patient	Gender
NRIC/FIN or Passport No.	Date of Birth (ddmmyyyy)

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):

2) Are you the patient's usual medical doctor? ❒ Yes ❒ No

If "Yes", since when? (ddmmyyyy)

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

3) Was the patient referred to you? ❒ Yes ❒ No

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.)

4) Have you referred the patient to any other doctor? ❒ Yes ❒ No

(i) Date referred (ddmmyyyy)

(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. tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, 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 **AIDS / Occupationally Acquired HIV / HIV due to Blood Transfusion, Assault or Organ Transplant (please circle the appropriate condition):**

(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 condition: (ddmmyyyy) | | | | | | | | |

2) Name and address of the doctor who *first* diagnosed the patient of the Human Immunodeficiency Virus ("HIV") due to (a) Blood Transfusion, (b) Assault, (c) Organ Transplant, and/or Occupationally Acquired HIV **(***please* ***circle*** *the appropriate condition).*

3) Please provide the dates of all HIV and antibody tests performed and their results.

Date of test	Name of tests	Results of tests

4) Please provide the full details of how the patient became infected with HIV, including the date and place.

5) Did the patient become infected with HIV through or resulted from:

(i) Organ Transplant? ❒ Yes ❒ No
If "Yes", please proceed to Question 6.

(ii) Blood transfusion? ❒ Yes ❒ No
If "Yes", please proceed to Question 6.

(iii) Accident while carrying out the normal professional duties of his/her occupation in Singapore? ❒ Yes ❒ No
If "Yes", please proceed to Question 7.

(iv) Physical or sexual assault? ❒ Yes ❒ No
If "Yes", please proceed to Question 8.

(v) Other means such as sexual activity, use of intravenous drugs? ❒ Yes ❒ No
If "Yes", please proceed to Question 9.

6) Please provide details on the **organ transplant** or **blood transfusion**.

(i) Was the organ transplant or blood transfusion medical necessary or given as part of a medical treatment? ❒ Yes ❒ No

If "Yes", please state:

(a) Reason(s) for the organ transplant or blood transfusion.

(b) Date of the transplant or transfusion: (ddmmyyyy)

(c) What was the organ transplanted?

(d) Was it due to congenital anomaly or defect? ❒ Yes ❒ No
If "Yes", please elaborate.

(ii) Please give name of doctor and address of the hospital / institution where the organ transplant or blood transfusion took place.

(iii) Date on which the patient was first diagnosed HIV positive (ddmmyyyy)

Please proceed to **Question 10**.

7) If the patient was infected with HIV which resulted from an **Accident** while carrying out the normal professional duties of his/her occupation in Singapore, please advise:

(i) Date and place of accident and full details.

(ii) Was the accident reported in accordance with established occupational procedures? ❒ Yes ❒ No

If "Yes", please give details including where and when it was reported (a copy of the report is madatory)

(iii) Patient's occupation:

(iv) Name of employer and address of company:

Please proceed to **Question 10**.

8) If the patient was infected with HIV which resulted from a **physical or sexual assault**, please advise:

(a) Date of the assault: (ddmmyyyyy)

(b) Date the incident was reported to the appropriate authority: (ddmmyyyy)

(c) Name of the authority:

(d) Whether a criminal case has been opened? ❒ Yes ❒ No

If "Yes", please attach a copy of the report/evidence.

Please proceed to **Question 10**.

9) If the patient was infected with HIV resulted from **other means** such as sexual activity, use of intravenous drugs, please state the exact causes and date of the HIV infection.

10) Was there evidence of sero-conversion from HIV negative to HIV positive occurring during 180 days after the documented Accident or Assault? ❒ Yes ❒ No
If "Yes", please provide full details, including test results and a copy of test results.

11) Was there a negative HIV antibody test conducted within 5 days from the documented Accident or Assault? If "Yes", please provide full details, including test results and a copy of test results. ❒ Yes ❒ No

12) Was the source of the infection established? ❒ Yes ❒ No

If "Yes", please provide full details of the definite source of (a) HIV tainted blood, (b) infected transplanted organ and/or (c) infected fluids, test results and a copy of test results (*Please **circle** the appropriate condition)*.

13) Is the patient suffering from:

(i) Thalassaemia major? ❒ Yes ❒ No

(ii) Haemophilia? ❒ Yes ❒ No

If "Yes" to (i) or (ii), please provide details as follows:

(a) Date of diagnosis (ddmmyyyy)

(b) Name of doctors and address of hospitals / institutions consulted.

(c) Nature of tests performed, date of tests performed and their results.

Date of test	Name of tests	Results of tests

14) Was the condition suffered by the patient caused directly or indirectly by:

(i) Alcohol abuse? ❒ Yes ❒ No

(ii) Drug abuse? ❒ Yes ❒ No

If "Yes" to (i) or (ii), please provide details.

15) Please provide details of **investigation** performed and **attach** a copy of the test results/reports.

16) Has a cure for AIDS / HIV become available prior to the time the patient is being infected? ❒ Yes ❒ No
If "Yes", please provide details.

17) Please provide details of **treatment**.

18) Is the patient still on follow-up at your hospital / clinic? ❒ Yes ❒ No

If "Yes", please advise date of next appointment (ddmmyyyy) | | | | | | | | |

If "No", please state date of discharge (ddmmyyyy) | | | | | | | | |

D) Other Information

1) What is the prognosis of the patient's condition?

2) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for the **AIDS / HIV infection or any possible related illness**? ❒ Yes ❒ No

If "Yes", please give details:

Name of doctor and Address of hospital/clinic	Date of first & last consulation	Reasons for consultation

3) Has the patient ever been hospitalised for the **AIDS / HIV infection** or its related symptoms or complications? If "Yes", please advise: ❒ Yes ❒ No

Date of hospitalisation	Reasons for hospitalisation	Treatment received (including operation, if any)	Name of doctor/surgeon & Address of hospital

4) Is there anything in the patient's **lifestyle** that could have increased the risk of HIV infection (e.g. drug use, sexual orientation, etc.). If "Yes", please elaborate. ❒ Yes ❒ No

5) Is there anything in the patient's **personal medical history** or **family history** which would have increased the risk of the AIDS / HIV infection? If "Yes", please give details: ❒ Yes ❒ No

Exact diagnosis	Age of diagnosis	Relationship with patient (if applicable)	Name of doctor & address of hospital/clinic

6) Please describe the nature and severity of the patient's **physical** and **mental** disability and limitation, if any.

7) 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. ❒ Yes ❒ No

8) Please provide us with any other additioanl information that will enable the Company to assess this claim.
10) Please enclose a copy of all reports including specialist or hospital reports, biopsy report, 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 & Offical Stamp of Doctor
Name of Doctor	
Date (ddmmyyyy)	