

**ATTENDING PHYSICIAN'S STATEMENT
STROKE / BRAIN ANEURYSM SURGERY OR CEREBRAL SHUNT INSERTION /
CAROTID ARTERY SURGERY**

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: <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: <u>No. of years of smoking</u> <u>No. of sticks per day</u> <u>Source of information</u>	
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. <u>Type of alcohol</u> <u>Quantity per Consumption</u> <u>Frequency (per week / month, etc)</u> <u>Source of information</u>	

C) Details of Illness											
1) Please provide details of Stroke :											
(i) Date of first consultation 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 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="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>										

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)	Please describe the initial episode: (i) Nature of episode:										
	(ii) Date of initial episode (ddmmyyyy) <table border="1" style="display: inline-table; border-collapse: collapse; width: 150px; height: 20px; vertical-align: middle;"> <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>										
	(iii) Duration of acute symptoms:										
5)	Was there any neurological deficit lasting for at least six (6) weeks after the initial episode of Stroke? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", (i) Please describe the neurological deficit.										
	(ii) Please describe the symptoms of dysfunction in the nervous system that are present on clinical examination.										
	(iii) How long have these sequelae been present since the initial episode?										
	(iv) Is the neurological deficit with its clinical symptoms likely to be permanent, lasting throughout the lifetime of the patient? Please elaborate with supporting evidence. <input type="checkbox"/> Yes <input type="checkbox"/> No										
6)	Has there been an infarction of brain tissue, haemorrhage, embolism and thrombosis from an extracranial source? If "Yes", please provide full details. <input type="checkbox"/> Yes <input type="checkbox"/> No										

7) Are the investigations or findings consistent with the diagnosis of a new Stroke? Yes No
 If "Yes", please provide details and attach a copy of all reports, CT Scan, MRI, laboratory test results, etc.

8) Please provide details of the surgery and/or other mode of treatment that had been performed, including type and date of treatment, and name and address of attending specialist.

9) Please confirm the following:

(i) Is this a Transient Ischaemic Attack? Yes No

(ii) Was the brain damaged due to an accident or injury, infection, vasculities, and inflammatory disease? Yes No

(iii) Was this condition due to vascular disease effecting the eye or optic nerve? Yes No

(iv) Was this condition due to ischaemic disorder of the vestibular system? Yes No

10. Has the patient undergone any **Brain Aneurysm Surgery**? Yes No
 If "No", please proceeds to **Question 11**.
 If "Yes", please proceeds as follow:

(i) Was an arteriogram / cerebral angiogram carried out? If "Yes", please advise: Yes No

(ii) Date of arteriogram performed (ddmmyyyy)

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 Please attach a copy of the report.

(iii) Was surgery carried out to correct intracranial aneurysm or arterio-venous malformation? Yes No
 If "Yes", please advise:

(iv) Date of surgery (ddmmyyyy)

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(v) Nature of surgery

(vi) Was surgery done via craniotomy? Yes No
 If "No", please state the type of surgery performed.

(vii) Please attach a copy of the tomography (CT) scan, magnetic resonance imagin (MRI), magnetic resonance angiograph (MRA) or angiogram.

11. Has the patient undergone any **Cerebral Shunt Insertion**? Yes No
 If "No", please proceeds to **Question 12**.
 If "Yes", please advise:

(i) How was this diagnosis established? Please include a copy of diagnostic investigation report.

(ii) Is the patient's condition of hydrocephalus congenital in nature? Yes No
 If "No", please indicate the cause of hydrocephalus.

(iii) Was there any intracranial pressure giving rise to neurological deficit as a result of hydrocephalus? If "Yes", please indicate the neurological deficit(s). Yes No

(iv) Was there surgical implantation of a shunt from the ventricles of the brain? Yes No
 If "Yes", please state:

(v) Date of shun insertion (ddmmyyyy)

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(vi) Was the surgery performed considered medically necessary by the consultant neurosurgeon? Yes No

(vii) Is there other mode of treatment other than shunt insertion, which could have been used to treat the patient's hydrocephalus? If "Yes", please state the nature of treatment and why this treatment was not used. Yes No

12. Did the patient suffer from **narrowing of the Carotid Artery**? Yes No
 If "No", please proceeds to **Section D**.
 If "Yes", please advise:

(i) Was an arteriography carried out? If "Yes", please provide a copy of report. Yes No

(ii) Please state the percentage of narrowing of the carotid artery.

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 %

(iii) Was Endarterectomy carried out to correct the carotid artery? Yes No
 If "Yes", please state the date of surgery (ddmmyyyy)

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 If "No", please state the type of treatment provided.

D) Other Information

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

2) Is the patient's condition or surgery performed in any way related or due to:

- (i) AIDS or HIV related illness? Yes No
- (ii) Use of drug not prescribed by a registered medical practitioner or drug abuse/ Yes No
- (iii) Alcohol abuse / misuse? Yes No
- (iv) Congenital or inherited disorder? Yes No
- (v) Attempted suicide or self-inflicted injuries? Yes No

If "Yes" for (i) to (v), please provide details and enclose a copy of the test result.

(a) Date of diagnosis (ddmmyyyy)

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(b) Exact diagnosis

(c) Name and address of doctor who first diagnosed the patient with the condition.

3) Is there anything in the patient's **personal medical history** which would have increased the risk of Stroke, intracranial aneurysm, arterio-venous malformation, hydrocephalus or narrowing of carotid artery or any related illness (e.g. hypertension, transient ischaemic attack, angina, other cardiovascular disease, congenital anomaly or defect, etc)? If "Yes", please give details: Yes No

Exact diagnosis

Date of diagnosis

Name of doctor & Address of hospital/clinic

4) Is there anything in the patient's **family history** which would have increased the risk of Stroke? Yes No
If "Yes", please give details:

Relationship with patient

Nature of condition

Age of onset

Source of information

5) Can you confirm that the advent of death is highly probable within:

(i) six (6) months? Yes No

(ii) twelve (12) months? Yes 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 **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 Stroke or any other related diseases? If "Yes", please give details: Yes No

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

8) Is the patient still on follow-up at your clinic? Yes No

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

If "No", please state date of discharge (ddmmyyyy), if any.

9) Please provide us with any other additional information that will enable us to assess this claim.

10) Please enclose a copy of all specialist or hospital reports, including magnetic resonance imaging, computerised tomography, or any reliable imagining techniques, laboratory test results, 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)	