Manulife

ATTENDING PHYSICIAN'S STATEMENT
END STAGE LUNG DISEASE / SURGICAL REMOVAL OF LUNG / SEVERE ASTHMA

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, asthma, chronic cough, 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 **End Stage Lung Disease, Severe Asthma and/or Lung condition**
(*please **circle** the appropriate condition):*

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

(i) Details of symptom(s) presented at first consultation, and date these symptoms **First** started.

(ii) What is the underlying cause(s) of the symptoms?

(iii) Exact Diagnosis of the condition:

ICD-10 Code (if applicable):

(iv) Date of **First** diagnosis (ddmmyyyy) | | | | | | | | |

(v) Date the patient **First** became aware of the condition (ddmmyyyy) | | | | | | | | |

2) Name and address of the Respiratory specialist who **First** diagnosed the patient of the **End Stage Lung Disease, Severe Asthma and/or Lung condition (***please **circle** the appropriate condition):*

3) (i) Please describe the patient's lung disease.

(ii) Has it reached end stage? ❒ Yes ❒ No

If "Yes", please state date of End Stage Lung Disease (ddmmyyyy) | | | | | | | | |

4) Please provide dates and details of all investigations carried out, including pulmonary function tests (especially current FEV1 and vital capacity readings).

Attach a copy of all the pulmonary function tests results.

5) Does the patient require extensive and permanent oxygen therapy for hypoxemia? ❒ Yes ❒ No

If "Yes", please advise:

(i) Start date (ddmmyyyyy) | | | | | | | | |

(ii) Frequency:

(iii) Place where oxygen therapy is administered:

6) Is there dyspnea at rest? ❒ Yes ❒ No

If "Yes", please describe severity and start date of symptoms, treatment, and comment on how this restricts daily activities.

7) Is the patient's arterial blood gas analysis with partial oxygen pressures less than 55mmHg (i.e. PaO2 < 55mmHg)? ❒ Yes ❒ No

If "Yes", please provide full details of all arterial blood gas analysis results.

If "No", please give the actual readings.

8) Did the patient undergo **pneumonectomy** (complete surgical removal of a lung)? ❒ Yes ❒ No

If "No", please proceed to **Question 9**.

If "Yes", please advise the following:

(i) Date of surgery (ddmmyyyy) | | | | | | | | |

(ii) Was the surgery performed considered medically necessary? ❒ Yes ❒ No

(iii) Reason(s) for requiring pneumonectomy:

(iv) Attach a copy of surgery and histology report.

9) Is the patient suffering or has the patient suffered from **Severe Asthma** condition? ❒ Yes ❒ No

If "No", please proceed to **Question 10**.

If "Yes", please advise the following:

(i) Was there evidence of an acute attack of Severe Asthma with persistent status asthmaticus? ❒ Yes ❒ No

If "Yes", please provide full details including the severity of the condition.

(ii) Was the patient hospitalised and required assisted ventilation with a mechanical ventilator? ❒ Yes ❒ No

If "Yes", please advise:

(a) Date of admission (ddmmyyyyy) | | | | | | | | |

(b) Date of discharge (ddmmyyyyy) | | | | | | | | |

(c) How many hours was the patient on mechanical ventilator? | | **Hours**

(d) Was the stated period continuous? ❒ Yes ❒ No

(e) Is the patient on continuous daily usage of oral corticosteriods to control asthma? ❒ Yes ❒ No

If "Yes", for how long has the patient been on oral corticosteriods? | | **Hours**

If "No", date of last consumption of oral corticosteroids (ddmmyyyy) | | | | | | | | |

10) Is the patient suffering or has the patient suffered from **Pulmonary Emboli**? If "Yes", please state: ❒ Yes ❒ No

(i) Date when the patient first consulted you for pulmonary emboli (ddmmyyyy)

(ii) Date of any subsequent pulmonary embolism. Please provide dates of every recurrence:

Date Consulted	Reason for Consultation	Treatment Provided	Patient's Response	Name & Address of Doctor

(iii) Is there surgical insertion of vena-cava filter? If "Yes", please state: ❒ Yes ❒ No

(a) Date of Surgery (ddmmyyyy)

(b) Was the surgery performed considered medically necessary by the consultant cardiologist? ❒ Yes ❒ No

(c) Is there other alternate treatment which could also treat the patient's condition? ❒ Yes ❒ No

If "Yes", please state the type of treatment.

11) Please provide details of current treatment**.**

12) 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) Has the patient ever been exposed to any substance that is likely to increase the risk of lung disease (e.g. exposure throug occupation or residential, etc.)? ❒ Yes ❒ No
If "Yes", please provide full details.

3) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for the **End Stage Lung Disease, Severe Asthma and/or Lung condition**? If "Yes", please give details: ❒ Yes ❒ No

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

4) Has the patient ever been hospitalised for the symptoms or complications of **End Stage Lung Disease, Severe Asthma and/or Lung condition?** 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

5) Is there anything in the patient's **personal medical history** or **family history** which would have increased the risk of the End Stage Lung Disease, Severe Asthma and/or Lung condition? ❒ Yes ❒ No
If "Yes", please give details:

Exact diagnosis	Date of diagnosis	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? ❒ Yes ❒ No
If "Yes", please provide full details why this view / course of action is taken

8) 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.

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

11) Please enclose a copy of all reports including specialist or hospital reports, lung histology report, ultrasound and radiological report, laboratory evidence, serial pulmonary function tests results, 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)	