Manulife

ATTENDING PHYSICIAN'S STATEMENT
KIDNEY FAILURE / SURGICAL REMOVAL OF ONE KIDNEY OR CHRONIC KIDNEY DISEASE

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 ❒ Yes ❒ No (e.g. cyst, tumour, hepatitis, diabetes, hypertension, hyperlipidaemia, anaemia, etc)

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 **Kidney Disease** condition:

(i) Date of first consultation for this condition (ddmmyyyy) | | | | | | | | |

(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) | | | | | | | | |

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

2) Please provide dates and details of investigation performed for the diagnosis and **attach** a copy of all relevant test reports (including eGFR level) which confirmed the diagnosis.

3) Please state if the kidney disease has resulted in permanent irreversible kidney function impairment? If "Yes", please list the eGFR level readings with dates. ❒ Yes ❒ No

Date	eGRF Level	Date	eGRF Level

4) Was the eGFR < 15mL/min / 1.73m^2 body surface area? ❒ Yes ❒ No

If "Yes", please state:

(i) How long has the result persisted? _____ days

(ii) Which kidney(s) has failed? _____ kidney(s)

5) Is there chronic kidney failure of both kidneys? ❒ Yes ❒ No

If "Yes", since when? (ddmmyyyy) | | | | | | | | |

6) Is the renal disease reversible? ❒ Yes ❒ No

7) Is the kidney failure at its end stage? ❒ Yes ❒ No

If "Yes", since when? (ddmmyyyy) | | | | | | | | |

8) Does the patient require permanent renal dialysis or kidney transplantation? ❒ Yes ❒ No

9) Is the patient currently undergoing regular peritoneal dialysis or haemodialysis? ❒ Yes ❒ No

If "Yes", please state:

(i) Date of first dialysis (ddmmyyyy) | | | | | | | | |

(ii) Number of dialyses per week _____ times / week

10) Has kidney transplantation been performed? If "Yes", please state: ❒Yes ❒ No

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

(ii) Which kidney(s) was removed? _____ kidney(s)

(iii) Was the surgical removal absolutely necessary? If "Yes", please explain. ❒ Yes ❒ No

(iv) Name and address of doctor who performed the surgery

11) Was the patient a recipient of the kidney transplantation? ❒ Yes ❒ No

12) Was a complete surgical removal of one kidney performed? If "Yes", please advise: ❒ Yes ❒ No

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

(ii) Was the surgical performed considered medically necessary by the consultant nephrologist? ❒ Yes ❒ No

(iii) Please provide the name and address of doctor who performed the surgery.

(iv) Please provide copies of operation report.

13) Has the patient previously suffered from kidney disease or related illnesses? ❒ Yes ❒ No

If "Yes", please provide details.

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 Kidney disease? If "Yes", please give details: ❒ Yes ❒ No

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

3) Is there anything in the patient's **family history** which would have increased the risk of the condition? ❒ Yes ❒ No

If "Yes", please give details:

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

4) 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.

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 disability and limitations, if any.

7) 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 anomaly or defect? ❒ Yes ❒ No

If "Yes" to (i)-(iv), please elaborate and attach a copy of the test results with this form:

(a) Date of diagnosis (ddmmyyyy) | | | | | | | | |

(b) Exact diagnosis

(c) Name and address of doctor who first diagnosed the patient with HIV, AIDS, drug abuse or alcohol abuse or congential anomaly.

8) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for **Kidney disease** or any other related diseases? If "Yes", please give details: ❒ Yes ❒ No

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

9) Please enclose copies of all reports including specialist or hospital reports, diagnostic test results, ultrasound, biopsy reports, surgical reports, laboratory evidence, 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)	