Manulife

ATTENDING PHYSICIAN'S STATEMENT
MAJOR BURNS

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:

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Main Office: 8 Cross Street #15-01, Manulife Tower, Singapore 048424
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Major Burns (1018)

Page 1 of 6

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, 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 **Major Burns**:

(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 of Major Burns (ddmmyyyy) ☐☐☐☐☐☐☐☐

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Page 2 of 6

2) Name and address of the doctor who **First** diagnosed the patient with Major Burns.

3) Were the burns self-inflicted, or in any way caused by alcohol or drugs abuse? ☐ Yes ☐ No

If "Yes", please elaborate with details.

4) Were the major burns a result of an Accident? ☐ Yes ☐ No

If "Yes", please advise:

(i) Date of Accident: (ddmmyyyy)

(ii) Time of Accident:

a.m. / p.m.

(iii) How the accident happened?

(iv) Was the accident reported to the police? ☐ Yes ☐ No

If "Yes", please attach a copy of police investigation report.

5) Please state the areas affected on the patient's body, the percentage of surface area, and the degree of burns in each affected area:
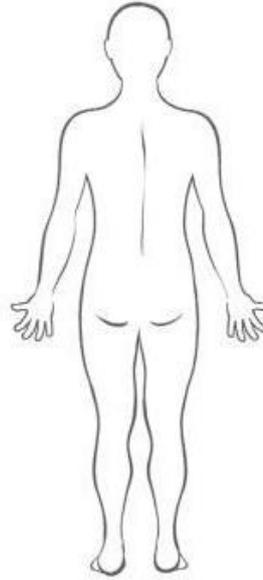
Areas affected	Percentage of surface area	Degree of burns

Major Burns (1018)

6) Please circle (in blue) the areas affected by burns in the picture below, and attach a copy of any relevant hospital reports such as the Burns report.
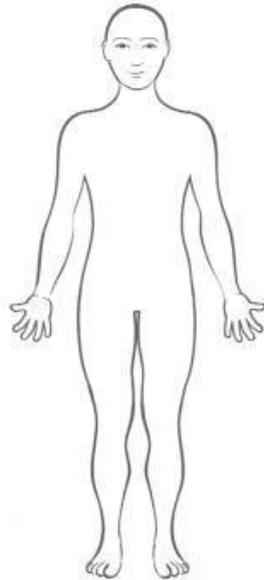
FRONT   **BACK**

7) Please provide full details of **treatment** received, including any skin grafts to repair damaged skin (past and/or contemplated).

8) Has the patient previously suffered from any prior burns or related conditions?   ☐ Yes ☐ No

   If "Yes", please provide details including type of treatment received, duration of hospitalisation, name of doctor and address of hospital.

| D) | **Other Information** |

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

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Page 4 of 6

2) Is there anything in the patient's **personal medical history** which would have increased the risk of accidents or burns, including congenital anomaly or defects? ☐ Yes ☐ No

If "Yes", please give details:

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

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

Relationship with patient	Nature of condition	Age of onset	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 **physical** and **mental** disability and limitation, if any.

Major Burns (1018)

7)	Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for **Major Burns 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

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

9) Please enclose a copy of all reports including specialist or hospital reports, Burns report, surgical report, police reports, 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)	

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