Manulife

# ATTENDING PHYSICIAN'S STATEMENT
# MAJOR HEAD TRAUMA / FACIAL RECONSTRUCTIVE SURGERY / CERVICAL SPINAL CORD INJURY

## 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 **Major Head Trauma, Facial Reconstructive Surgery, and/or Cervical Spinal Cord Injury** condition:

**(***please **circle** the appropriate condition):*

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

| | | | | | | | |
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(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 illness/condition (ddmmyyyy) | | | | | | | | |

2) Please provide dates and details of all investigation performed to establish the **diagnosis** and attach a copy of all relevant investigation reports.

3) Was the condition a result of an **Accident**? ❒ Yes ❒ No

If "No", please proceed to Question 4 in page 4.

If "Yes", please advise:

(i) Date of Accident (ddmmyyyy) | | | | | | | | |

(ii) Time of Accident | | a.m. / p.m.

(iii) Place of Accident

(iv) Describe in details how the accident happened.

(v) Describe the extent and severity of the brain, facial, spinal cord and/or bodily injuries/disability sustained, including exact site(s) of the body.

(vi) Was the accident reported to the police? ❒ Yes ❒ No

If "No", why not?

If "Yes", please provide the following information and **attach** a copy of the police report.

Police Division | Name of Police Officer-in-charge

(vii) Was the patient under the influence of alcohol and/or drugs at the time of accident? ❒ Yes ❒ No

If "Yes", please elaborate (e.g. result of blood alcohol concentration, alcohol breath test; name of drugs, quantity consumed, etc.)

(viii) Did the injury result from a self-inflicted act? ❒ Yes ❒ No

If "Yes", please provide full details.

(ix) Did the patient have any medical condition(s) that had contributed to the accident (e.g. fits) ❒ Yes ❒ No

If "Yes", please provide full details.

4) Was the patient hospitalised for the condition or its related symptoms or complications? ❒ Yes ❒ No

If "Yes", please provide full details.

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

5) Did the patient refuse any form of medical treatment, including surgery, which might have prevented or reduced the severity of the impairment? ❒ Yes ❒ No

If "Yes", please provide full details.

6) If the patient had suffered from:

(i) Major Head Trauma, please proceed to **Section D**.
(ii) Facial Injury, proceed to **Section E**.
(iii) Cervical Spinal Cord Injury, proceed to **Section F**.

**D) This section is applicable for Major Head Trauma only.**

1) Describe the exact nature of the brain injury.

(As the policy specifies that the brain injury must be demonstrated by a modern scanning or imaging techniques, please **attach** a copy of the Magnetic Resonance Imaging or Computerised Tomograpy Scan.)

2) Was there any form of neurological deficit still present 6 weeks after the date of the accident? ❒ Yes ❒ No

If "Yes", please provide full details of the neurological deficits.

3) Is the neurological deficit likely to be permanent, lasting throughout the lifetime of the patient? ❒ Yes ❒ No

If "No", please state the date of recovery *or* date for which the patient is expected to recover from the neurological deficit (ddmmyyyy)

| | | | | | | | |
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If "Yes", please support with evidence.

4) Name and address of the neurologist who **First** diagnosed the patient with Major Head Trauma.

5) Was there any surgery done? ❒ Yes ❒ No

If "Yes", please provide full details and attach a copy of the surgery note.

6) Please provide details of current **treatment**, including any physical and speech therapy, if any.

**E) This section is applicable to Facial Reconstructive Surgery only.**

1) Was there any reconstructive surgery above the neck (restoration or reconstruction of the shape of, and appearance of facial structures which were defective, missing or damaged or misshapen) to correct disfigurement as a direct result of the accident? ❒ Yes ❒ No

If "Yes", please state:

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

(ii) Was the reconstructive surgery solely for treatment relating to teeth and/or any other dental restoration alone and/or cosmetic nose surgery? ❒ Yes ❒ No

If "No", please provide the reconstructive surgery in details.

(iii) Name and address of the specialist who performed the surgery.

**F) This section is applicable to Cervical Spinal Cord Injury only.**

1) Describe the exact nature of the cervical spinal cord injury.
(As the policy specifies that the said injury must be demonstrated by a modern scanning or imaging techniques, please **attach** a copy of the Magnetic Resonance Imaging or Computerised Tomograpy Scan.)

2) Has the acciental cervical spinal cord injuries resulted in the loss of use of at least one entire limb for at least 6 weeks ? If "Yes", please provide details. ❒ Yes ❒ No

**G) Other Information**

1) Please describe and elaborate on the nature and severity of the patient's **physical** and **mental** disability and limitation when you last saw him/her (e.g. loss of memory, muscle control, speech, vision, etc.).

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

3) Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for **Head Trauma/Facial injury/ cervical spinal cord injury, or any possible related illness**, especially any consultations concerning neruological symptoms or complaints? ❒ Yes ❒ No
If "Yes", please give details:

| Name of doctor and Address of hospital/clinic | Date of first & last consulation | Reasons for consultation |
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| 5) Please provide us with any other additional information that will enable the Company to assess this claim. |
| 6) Please enclose a copy of all reports including specialist or hospital reports, laboratory evidence, magnetic resonace image, computed tomography, cerebrospinal fluid analysis result, surgical report, etc. that are available. |

| **H) 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) | |