Manulife

ATTENDING PHYSICIAN'S STATEMENT
MUSCULAR DYSTROPHY

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. scoliosis, tumour, stroke, 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 the **Muscular Dystrophy**:

(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 full details and results of all **investigation** (with dates) performed to establish the diagnosis (e.g. muscle biopsy, electromyogram, enzyme tests such as creatine kinase, etc.). Please **attac**h a copy of the relevant test reports.

3) Name and address of the **neurologist** who **Firs**t diagnosed the patient with Muscular Dystrophy.

4) Please describe in details (with dates) the extent of neurological deficits suffered by the patient.

5) Are there signs of progressive impairment? ❒ Yes ❒ No

If "Yes", please elaborate (with dates) on how the Muscular Dystrophy has deteriorated over time.

6) Please provide details of current **treatment** received for Muscular Dystrophy, including the name and dosage of medication, operation contemplated (if any)?

7) Has the patient ever been hospitalised for Muscular Dystrophy or its related complications? ❒ Yes ❒ No

If "Yes", please advise:

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

D) Additional Information

1) Based on your most recent records, please circle as applicable in relation to the patient's ability to perform the Activities of Daily Living (ADLs), whether aided or unaided by special equipment, device and/or apparatus (and not pertaining to human aid).

Definition of ADL	**Extent of Independence**	**Yes / No**	**If patient always requires another person's help, please state: (a) Reasons, and (b) For how long has he/she been unable to do so?**
Washing/Bathing: The ability to wash in the bath or shower (including getting into and out of the bath and shower) or wash satisfactorily by other means.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment • Always require another person's assistance throughout the entire activity	**Yes / No** **Yes / No** **Yes / No**	
Dressing: The ability to put on, takes off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment • Always require another person's assistance throughout the entire activity	**Yes / No** **Yes / No** **Yes / No**	
Transferring: The ability to move from a bed to an upright chair or wheelchair and vice versa.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment • Always require another person's assistance throughout the entire activity	**Yes / No** **Yes / No** **Yes / No**	

D) Additional Information (continue)

1) Based on your most recent records, please circle as applicable in relation to the patient's ability to perform the Activities of Daily Living (ADLs), whether aided or unaided by special equipment, device and/or apparatus (and not pertaining to human aid).

Definition of ADL	Extent of Independence	Yes / No	If patient <u>always requires</u> another person's help, please state: (a) Reasons, and (b) For how long has he/she been unable to do so?
Mobility: The ability to move indoors from room to room on level surfaces.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment • Always require another person's assistance throughout the entire activity	**Yes / No** **Yes / No** **Yes / No**	
Toileting: The ability to use the lavatory or otherwise managed bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment • Always require another person's assistance throughout the entire activity	**Yes / No** **Yes / No** **Yes / No**	
Feeding: The ability to feed oneself once food has been prepared and made available.	• Able to perform independently and without any assistance. • Able to perform with aid of special equipment • Always require another person's assistance throughout the entire activity	**Yes / No** **Yes / No** **Yes / No**	

2) What tests did you use to establish the patient's function for each of the ADLs (e.g. standardised functional assessments, observation of patient performaing ADL-specific tasks, etc.)?

3) If your assessment of the patient's function for each of the ADLs was taken from report(s) provided by the patient or relatives, please attach a copy of such report(s).

4) 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.

5) Please describe and elaborate on the nature and severity of the patient's **physical and mental** disability and limitation, if any.

6) Is there anything in the patient's **personal medical history** which would have increased the patient's risk of suffering from Muscular Dystrophy? If "Yes", please give details: ❒ Yes ❒ No

Type of Lifestyle / Exact diagnosis	Date of diagnosis	Name of doctor & Address of hospital/clinic

7) Is there anything in the patient's **family history** which would have increased the patient's risk of suffering from Muscular Dystrophy? If "Yes", please give details: ❒ Yes ❒ No

Relationship with patient	Nature of condition	Age of onset	Source of information

8)	Are you aware of any other doctor(s) (in Singapore or Overseas) whom the patient consulted for the **Muscular Dystrophy** or any other related diseases? ❒ Yes ❒ No If "Yes", please give details: Name of doctor and Address of hospital/clinic — Date first & last consulted — Reasons for consultation
9)	Please provide us with any other additional information that will enable the Company to assess the claim.
10)	Please enclose a copy of all reports including specialist or hospital reports, magnetic resonance imaging, computerised tomography or other reliable imaging techniques, laboratory evidence, 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)	