CRITICAL ILLNESS CLAIM FORM
ATTENDING PHYSICIAN'S STATEMENT
BRAIN & SPINE RELATED CONDITIONS

Policy/Policies No. _____

1. This printed form is issued on receipt of notice of illness, and is no way an admission of liability.
2. This form is to be completed by the Attending Doctor at claimant's expenses.
3. The original or certified true copy of the related investigation reports must be attached to substantiate the claim. *(including but not limited to Computed Tomography Scan, Magnetic Resonance Imaging, Electroencephalography Report, Lumbar Puncture, etc.)*

This claim is being filed for : *(Please tick [√] in the appropriate box and complete **ALL** sections in this form.)*
*For **Section C: Additional Details of Illness**, please complete according to the **Group** specified for the respective illness as below.*

	Group:		Group:
☐ Stroke	A, B, C1, D	☐ Head Trauma	A, B, C4, D
☐ Carotid Artery Surgery	A, B, C1, D	☐ Multiple Sclerosis	A, B, C4, D
☐ Stroke Requiring Carotid Endarterectomy Carotid Endarterectomy Surgery	A, B, C1, D	☐ Progressive Supranuclear Palsy	A, B, C4, D
		☐ Alzheimer's Disease or Severe Dementia	A, B, C4, D
		☐ Organic Degenerative Brain Disorder	A, B, C4, D
☐ Brain Surgery	A, B, C, D	☐ Parkinson's Disease	A, B, C4, D
☐ Surgery for Subdural Haematoma	A, B, C, D	☐ Encephalitis	A, B, C4, D
☐ Brain Aneurysm Surgery	A, B, C, D	☐ Bacterial Meningitis	A, B, C4, D
☐ Cerebral Aneurysm Requiring Brain Surgery	A, B, C, D	☐ Tuberculous Myelitis	A, B, C4, D
☐ Cerebral Shunt Insertion	A, B, C, D	☐ Meningeal Tuberculosis	A, B, C4, D
☐ Hydrocephalus	A, B, C, D	☐ Poliomyelitis	A, B, C4, D
		☐ Creutzfeldt – Jakob Disease	A, B, C4, D
☐ Benign Brain Tumour	A, B, C2, D		
☐ Surgical Removal of Pituitary Tumour	A, B, C2, D	☐ Apallic Syndrome	A, B, C6, D
☐ Coma	A, B, C3, D	☐ Severe Epilepsy	A, B, C7, D
☐ Motor Neuron Disease	A, B, C5, D	☐ Accidental Fracture of Spinal Column	A, B, C8, D
☐ Myasthenia Gravis	A, B, C5, D	☐ Multiple Root Avulsions of Brachial Plexus	A, B, C8, D
☐ Peripheral Neuropathy	A, B, C5, D	☐ Surgery for Idiopathic Scoliosis	A, B, C8, D
☐ Spinal Cord Disease or Injury Resulting in Bowel & Bladder Dysfunction	A, B, C5, D	☐ Type 1 Juvenile Spinal Amyotrophy	A, B, C8, D

SECTION A : PERSONAL PARTICULAR OF PATIENT

Name : _____ Age/Sex : _____

NRIC/Passport : _____ Occupation : _____

1. Please give details of patient's past medical history, lifestyle *(e.g. smoker, drinker, etc.),* comorbidities and any information that are deemed necessary.

_____

_____

2. Are you aware of any members of patient's close family who have suffered from this or any similar condition? If yes, please give details.

_____

_____

SECTION B : GENERAL INFORMATION & DETAILS OF ILLNESS

1. Are you the patient's Usual Medical Attendant? If so, since when? ☐☐☐☐☐☐ (DD/MM/YY)

2. If no, please give name and address of his/her Usual Medical Attendant if it is known to you.

_____

_____

3. Date you first saw the patient for this condition. ☐☐☐☐☐☐ (DD/MM/YY)

4. Was the patient being referred to you? If yes, please indicate name and address of the referral doctor.

_____

_____

5. What were the symptoms the patient complaint of when he/she first saw you?

_____

_____

6. According to the patient, how long had he/she been experiencing these symptoms prior to consulting you?

_____

7. In your professional opinion, how long would it take for the patient condition to develop?

_____

8. What was your final diagnosis established?

_____

_____

   (a) On what date was the diagnosis established? ☐☐☐☐☐☐ (DD/MM/YY)

   (b) On what date was the patient first made aware of it? ☐☐☐☐☐☐ (DD/MM/YY)

9. Was the condition diagnosed related directly, indirectly, partly or wholly to:

   (a) Congenital defect or disease YES / NO

   (b) Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection YES / NO

   (c) Alcohol or drug abuse YES / NO

10. Was the patient suffering from any of the following comorbidities? *(Please tick [√] in the appropriate box.)*

☐ Hypertension ☐ Diabetes Mellitus ☐ Hyperlipidaemia

☐ Others, kindly specify : _____

11. Kindly provide details for Q10.

Date	Diagnosis	Treatment	Doctor/Hospital

12. Kindly provide details of the diagnosis. *(e.g. exact site, type of defect/injury, etc.)*

_____

_____

13. What was the underlying cause?

_____

14. Kindly provide details of the investigation test or imaging done that confirms the diagnosis.

Date	Type of Investigation	Investigation Result

15. Kindly provide details of the treatment.

_____

_____

16. Was there any surgery performed? If yes, kindly provide details.

Date	Type of Surgery	Surgical Approach *(e.g. craniotomy, burr hole, endoscopy, etc.)*	Surgeon/Hospital

17. Could the patient be treated conservatively other than the above surgical procedure?
    (a) If yes, kindly provide details.

    _____

    (b) If no, kindly explain why the procedure was medically necessary.

    _____

18. Please give the date that you last examined the patient. ☐☐☐☐☐☐ (DD/MM/YY)
    (a) Was there any residual neurological deficit? If yes, kindly provide details.

    _____

    _____

    (b) Kindly advise if the condition is likely to be permanent or temporary.

    _____

SECTION C : ADDITIONAL DETAILS OF ILLNESS

PART C1 : Please complete this portion if the diagnosis established falls under the below description. If NO, please ignore.

- ***Stroke***
- ***Stroke Requiring Carotid Endarterectomy Surgery***
- ***Carotid Artery Surgery***

1. Was there a narrowing of the carotid artery? YES / NO
   (a) If yes, kindly provide details of the type of carotid artery involved.

   _____

   (b) Please provide the percentage of narrowing. _____ %

   (c) Was the condition of stroke caused by the narrowing of carotid artery? YES / NO

2. Please tick [√] if the diagnosis falls under any of the following.
   - ☐ Transient ischemic attacks
   - ☐ Any reversible ischaemic neurological deficit
   - ☐ Vertebrobasilar ischaemia
   - ☐ Cerebral symptoms due to migraine
   - ☐ Cerebral injury resulting from trauma or hypoxia
   - ☐ Vascular disease affecting the eye or optic nerve or vestibular functions
   - ☐ **None of the above**

PART C2 : Please complete this portion if the diagnosis established falls under the below description. If NO, please ignore.

- ***Benign Brain Tumour***
- ***Surgical Removal of Pituitary Tumour***

1. Please give details of the tumour:

   (a) Type of the tumour _____

   (b) Site of the tumour _____

   (c) Staging and classification of the tumour _____

2. Was biopsy done? If yes, kindly provide the results. ☐☐☐☐☐☐ (DD/MM/YY)

   _____

   _____

3. Kindly confirm on the following:

   (a) Was the condition life threatening? YES / NO

   (b) Has the tumour caused damage to the brain? YES / NO

   (c) Was there characteristic sign of increased intra-cranial pressure? YES / NO
   If yes, kindly provide details.

   _____

4. Was the diagnosis fall under any of the following? *(Please tick [√] in the appropriate box, if applicable.)*

   ☐ Cysts
   ☐ Granulomas
   ☐ Haematomas
   ☐ Tumours in the pituitary gland
   ☐ Tumours in the spine
   ☐ Tumours of the acoustic nerve
   ☐ Malformations in or of the arteries or veins of the brain
   ☐ **None of the above**

PART C3 : Please complete this portion if the diagnosis established falls under the below description. If NO, please ignore.

- ***Coma***

1. Date of onset for coma ☐☐☐☐☐☐ (DD/MM/YY)

2. Did the patient react to any external stimuli or internal needs? Kindly provide the clinical findings or observation.

   _____

   _____

3. Was life support system required? Kindly provide details.

   _____

   _____

4. Kindly provide the Glasgow Coma Scale or any other measurement for the severity of coma.

Date	Severity of Coma *(e.g. Glasgow Coma Scale, etc.)*

5. Kindly provide the date when patient regained consciousness. *(if applicable)* ☐☐☐☐☐☐ (DD/MM/YY)

6. Was the coma resulting from any of the following? *(Please tick [√] in the appropriate box, if applicable.)*

   ☐ Self-inflicted injury
   ☐ Medically induced
   ☐ **None of the above**
   ☐ Alcohol abuse
   ☐ Drug abuse

PART C4 : Please complete this portion if the diagnosis established falls under the below description. If NO, please ignore.

- ***Head Trauma***
- ***Multiple Sclerosis***
- ***Progressive Supranuclear Palsy***
- ***Alzheimer's Disease or Severe Dementia***
- ***Organic Degenerative Brain Disorder***
- ***Parkinson's Disease***
- ***Encephalitis***
- ***Bacterial Meningitis***
- ***Tuberculous Myelitis***
- ***Meningeal Tuberculosis***
- ***Poliomyelitis***
- ***Creutzfeldt-Jakob Disease (Mad Cow Disease)***

1. Please grade the patient's ability to perform the following Activities of Daily Living either with or without use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons, as follows:

   1 - Complete functional limitation in performing the ADL as described

   2 - Substantial limitation in performing the ADL. Requires one to one assistance to perform the activity described

   3 - Minor limitation in performing the ADL. Assistance required on an intermittent basis or with some minor part of the activity or able to perform the ADL with use of an aid or appliance

   4 - No functional limitation, able to perform the ADL independently

   Date of assessment ☐☐☐☐☐☐ (DD/MM/YY) Please circle the relevant answers.

   (a) Transfer and mobility – The ability to get in and out of a chair or move from one room to room without requiring any physical assistance. 1 / 2 / 3 / 4

   (b) Continence – The ability to voluntarily control bowel and bladder functions as to maintain personal hygiene. 1 / 2 / 3 / 4

   (c) Dressing – The ability to put on and take off all necessary items of clothing without requiring assistance of another person. 1 / 2 / 3 / 4

   (d) Bathing/Washing – The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means. 1 / 2 / 3 / 4

   (e) Eating – The ability to perform all tasks of getting food into the body once it has been prepared. 1 / 2 / 3 / 4

2. What was the underlying cause? *(Please tick [√] in the appropriate box, if applicable.)*

   ☐ Idiopathic ☐ Drug abuse ☐ Infection
   ☐ Autoimmune ☐ Alcohol abuse ☐ Others, kindly specify:
   ☐ Trauma ☐ Toxin

   _____

***For Question 3 – 6, please complete this portion if patient was diagnosed with any of the illnesses below.**

3. Additional information for **<u>Alzheimer's Disease / Severe Dementia / Organic Degenerative Brain Disorder</u>**:

   (a) Is the condition irreversible? If no, kindly provide details. YES / NO

   _____

   (b) Is the brain disorder organic? If no, kindly provide details. YES / NO

   _____

4. Additional information for **<u>Parkinson's Disease</u>**:

   (a) Can the condition be controlled with medication? YES / NO
   If yes, kindly provide details of the medication given.

   _____

(b) Was there sign of progressive impairment? If yes, kindly provide details. YES / NO

_____

5. Additional information for **Multiple Sclerosis**:

(a) Were the neurological deficits produced by symptoms referable to tract (white matter) involving the optic nerves, brain stem and spinal cord? YES / NO

(b) Was there a multiplicity of discrete lesions? YES / NO

(c) Was there a well-documented history of exacerbation and remission? YES / NO

6. Additional information for **Encephalitis / Bacterial Meningitis / Tuberculous Myelitis / Meningeal Tuberculosis / Poliomyelitis / Creutzfeldt-Jakob Disease**:

(a) What was the underlying cause? *(Please tick [√] in the appropriate box, if applicable.)*

☐ Bacteria ☐ Fungus ☐ Others, kindly specify:
☐ Virus ☐ Parasite

_____

(b) Please state the name of the pathogen(s).

_____

(c) Kindly provide the cerebrospinal fluid (CSF) finding or any other investigation test result that confirms the presence of the above pathogen(s).

Date	CSF Finding / Investigation Result

(d) Kindly provide the electroencephalography (EEG) finding (for **Creutzfeldt-Jakob Disease**).

Date	EEG Finding

PART C5 : Please complete this portion if the diagnosis established falls under the below description. If NO, please ignore.

- ***Motor Neuron Disease***
- ***Myasthenia Gravis***
- ***Peripheral Neuropathy***
- ***Spinal Cord Disease or Injury Resulting in Bowel and Bladder Dysfunction***

1. Kindly provide details on the neurological deficit.

Sensory	Motor	Autonomic

2. What was the underlying cause? *(Please tick [√] in the appropriate box, if applicable.)*

☐ Diabetes Mellitus ☐ Drug abuse ☐ Infection
☐ Autoimmune ☐ Alcohol abuse ☐ Others, kindly specify:
☐ Trauma ☐ Tumour _____

***For Question 3 – 6, please complete this portion if patient was diagnosed with any of the illnesses below.**

3. Kindly select the exact diagnosis of the **Motor Neuron Disease**:

☐ Spinal muscular atrophy ☐ Amyotrophic lateral sclerosis
☐ Progressive bulbar palsy ☐ Primary lateral sclerosis
☐ Others, kindly specify : _____

4. For **Myasthenia Gravis**, please select the degree of permanent muscle weakness in accordance to the Myasthenia Gravis Foundation of America Clinical Classification: Class I / II / III / IV / V

5. Additional information for **Peripheral Neuropathy**:

(a) Was the diagnosis confirmed by nerve conduction studies? YES / NO
If yes, kindly provide details.

Date	Investigation Result

(b) Was there a permanent need to use a walking aid or a wheelchair? YES / NO

6. Was the diagnosis of **Spinal Cord Disease or Injury** fall under any of the following? *(Please tick [√] in the appropriate box, if applicable.)*

☐ Spina bifida ☐ Meningomyelocele
☐ Meningocele ☐ **None of the above**

PART C6 : Please complete this portion if the diagnosis established falls under the below description. If NO, please ignore.

- ***Apallic Syndrome***

1. Was there a total damage of the brain cortex with brainstem intact? YES / NO
   If no, kindly provide details.

   _____

PART C7 : Please complete this portion if the diagnosis established falls under the below description. If NO, please ignore.

- ***Severe Epilepsy***

1. Kindly confirm the type of Epilepsy.
   - ☐ Tonic-clonic seizure
   - ☐ Petit mal/absence seizure
   - ☐ Grand mal seizure
   - ☐ Febrile seizure
   - ☐ Others, kindly specify : _____

2. Kindly provide the electroencephalography (EEG) finding.

Date	EEG Finding

3. Kindly provide the number of seizure attack per week. _____ times per week

4. Kindly provide details on the medications prescribed and how long have the patient been taking the medication.

   _____

5. Is the epilepsy condition resistant to optimal therapy? YES / NO
   If yes, please provide results of the drug serum-level testing.

   _____

PART C8 : Please complete this portion if the diagnosis established falls under the below description. If NO, please ignore.

- ***Accidental Fracture of Spinal Column***
- ***Multiple Root Avulsions of Brachial Plexus***
- ***Surgery for Idiopathic Scoliosis***
- ***Type 1 Juvenile Spinal Amyotrophy***

1. Please give details of the **Fracture of Spinal Column**:
   (a) Location of fracture _____
   (b) Type of fracture _____

2. Additional information for **Multiple Root Avulsions of Brachial Plexus**:
   (a) Kindly provide details on the nerve roots avulsed. *(e.g. type of nerve root, number of nerve root avulsed, etc.)*

   _____

   _____

(b) Was the avulsion confirmed by electrodiagnostic study? YES / NO
If yes, kindly provide details.

Date	Investigation Result

3. Additional information for **Idiopathic Scoliosis**:
   (a) Kindly provide the degree of curve of the spine _____ degree
   (b) Was the underlying cause of the condition is unidentifiable? YES / NO
   If no, what was the underlying cause?

   _____

   (c) Was the spinal deformity associated with congenital defects or neurolmuscular disease? If yes, kindly provide details. YES / NO

   _____

4. Additional information for **Type I Juvenile Spinal Amyotrophy**:
   (a) Was there a progressive dysfunction of the anterior horn cells in the spinal cord and brainstem cranial nerves with profound weakness and bulbar dysfunction? YES / NO
   (b) Was the condition confirmed by electromyography and muscle biopsy? YES / NO
   If yes, kindly provide details.

Date	Investigation Result

SECTION D : OTHER INFORMATION

1. Has the patient previously received treatment for the above condition elsewhere? If yes, kindly provide details such as date, diagnosis, treatment, treating doctor and hospital.

   _____

   _____

2. Please give names and addresses of all other Medical Practitioner whom, to your knowledge, had attended to the patient for this condition.

   _____

   _____

3. Please state from your records the details of all illnesses, accidents, surgical operations or diseases from which the patient had suffered or had been treated. *(Please use additional sheet, if necessary.)*

Date	Diagnosis	Treatment	Doctor/Hospital

4. Please give any other information which you feel would be helpful in the assessment of your patient's claim.

   _____

   _____

I hereby certify that I have examined the above patient and that the injury/sickness stated above represent my medical opinion of the patient's condition.

Name of Doctor : _____

_____ Qualification / Specialty : _____

Signature
Date :

_____ _____

Doctor's Stamp Hospital/Clinic Stamp