CRITICAL ILLNESS CLAIM
ATTENDING PHYSICIAN'S STATEMENT
MOTHER RELATED CONDITIONS

Policy 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 Imaging Report (CT Scan, MRI, Ultrasound etc.), EEG Report, Histopathology Report, Laboratory Test Report etc.)*

This claim is being filed for : *(Please tick [√] in the appropriate box and complete according to the sections specified for the respective illness as below.)*

	Sections		Sections
Pregnancy Complication		**Infectious Disease**	
☐ Placenta Increta/ Percreta	A, B, F	☐ Zika Virus	A, B, F
☐ Ectopic Pregnancy Termination	A, B, F	☐ MERS	A, B, F
☐ Abruptio Placentae	A, B, C(1), F	☐ Ebola	A, B, F
☐ Amniotic Fluid Embolism	A, B, C(2), F	☐ SARS	A, B, F
☐ Eclampsia	A, B, C(3), F	☐ Influenza A – Avian influenza A (H7N9) & A (H5N1)	A, B, F
☐ Postpartum Haemorrhage Requiring Hysterectomy	A, B, C(4), F	☐ Nipah Virus Encephalitis	A, B, F
☐ Acute Fatty Liver of Pregnancy	A, B, C(5), F	☐ Japanese Encephalitis	A, B, F
☐ Disseminated Intravascular Coagulation (D.I.C.)	A, B, C(6), F	☐ Severe Measles	A, B, D(1), F
Hospitalisation Condition		☐ Severe Hand Foot Mouth Disease	A, B, D(2), F
☐ Complications of lactational mastitis	A, B, F	☐ Chikungunya Fever	A, B, D(3), F
☐ Repair of 4th degree perineal tear	A, B, F	☐ Typhoid Fever	A, B, D(4), F
☐ Septic pelvic thrombophlebitis	A, B, F	☐ Rabies	A, B, D(5), F
☐ Surgical site infection following Caesarean section	A, B, F	☐ Creutzfeldt-Jakob disease	A, B, D(6), F
☐ Uterine infection or transfusion due to retained placenta following birth	A, B, F	☐ Malaria	A, B, D(7), F
☐ Inpatient psychiatric treatment	A, B, C(7), F	☐ Severe Dengue Hemorrhagic Fever	A, B, D(8), F
☐ Post-natal Anaemia	A, B, C(8), F	**Psychotherapy Treatment**	
☐ Puerperal Infection and Shock	A, B, C(9), F	☐ Major Depressive Disorders (MDD)	A, B, E, F
☐ Pulmonary embolism	A, B, C(10), F	☐ Generalised Anxiety Disorders (GAD)	A, B, E, F

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 : DETAILS OF ILLNESS

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

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

_____

_____

3. What were the symptoms presented to you?

_____

_____

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

_____

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

_____

6. Please state the final diagnosis established and provide details below.

_____

(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)*
(c) Gestational Week as at the date of diagnosis *(if applicable)*:	*weeks*
(d) Date of childbirth *(if applicable)*:	*(DD/MM/YY)*

7. Was the diagnosis confirmed by you? **YES / NO**
If no, please state the name and specialty of the doctor who confirmed the diagnosis.

_____

8. Please provide full details of the diagnosis. *(e.g. exact site, type, associated complications etc.)*

_____

_____

9. What was the underlying cause?

_____

10. Was patient hospitalized for the above condition? If yes, please provide details below.

Hospitalisation			
Admission Date *(DD/MM/YY)*		Discharge Date *(DD/MM/YY)*	
Admission Time *(am/pm)*		Discharge Time *(am/pm)*	
ICU / HDU *(if applicable)*			
From *(DD/MM/YY)*		To *(DD/MM/YY)*	

(Please attach copy of itemized bill for the admission.)

a. Was the hospitalization and/ or confinement in ICU/ HDU **medically necessary**? Please substantiate.

_____

_____

11. Was the condition accompanied by Gestational Diabetes Mellitus ("GDM")? **YES / NO**
If yes, kindly provide the date of diagnosis and details below: ☐☐☐☐☐☐ *(DD/MM/YY)*

(a) Fasting plasma glucose reading: _____ mmol/L

(b) Venous plasma glucose reading two hours after 75 gram oral glucose intake: _____ mmol/L

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

Date	Type of Investigation	Investigation Result

13. Was the condition diagnosed arising from or accelerated, directly or indirectly, wholly or partly, by any one of the following occurrences *(Please tick [√] in the appropriate box.):*

☐ Alcohol or drug abuse

☐ Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection

☐ Suicide, attempted suicide or intentionally self-inflicted injuries while sane or insane

☐ Abortion or elective termination of pregnancy, which is not due to medical conditions

☐ Pregnancy conceived through artificial insemination and/ or assisted conceptions (IVF, IUI, ICI etc.), with two (2) or more unborn children (If yes, please specify: _____)

☐ Pregnancy with three (3) or more unborn children (If yes, please specify: _____)

☐ Experimental treatment or unlicensed test (If yes, please specify: _____)

☐ **None of the above**

14. Was any of the following treatment given?

☐ Intravenous antibiotics ☐ Anticoagulation ☐ Blood transfusion

☐ Frozen plasma ☐ Platelet concentrates ☐ **None of the above**

15. Kindly provide details of the treatment.

_____

_____

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

Date	Type of Surgery	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.

_____

SECTION C : ADDITIONAL DETAILS - PREGNANCY COMPLICATION / HOSPITALISATION CONDITION

Please complete the question corresponding to the respective illness as specified below.

1. ***Abruptio Placentae***
2. ***Amniotic Fluid Embolism***
3. ***Eclampsia***
4. ***Postpartum Haemorrhage Requiring Hysterectomy***
5. ***Acute Fatty Liver of Pregnancy***
6. ***Disseminated Intravascular Coagulation (D.I.C.)***
7. ***Inpatient psychiatric treatment***
8. ***Post-natal Anaemia***
9. ***Puerperal Infection and Shock***
10. ***Pulmonary embolism***

1. Abruptio Placentae

(a) Was there premature separation of the placenta from the uterine wall? **YES / NO**

(b) Has the condition caused fetal death? **YES / NO**

2. Amniotic Fluid Embolism

(a) Has the condition caused life threatening complications below:

i. Pulmonary edema **YES / NO**

ii. Cardiac arrest **YES / NO**

iii. Fetal death **YES / NO**

3. Eclampsia

(a) Were there signs and symptoms of pre-eclampsia? **YES / NO**

(b) Was there occurrence of the complications below during pregnancy or shortly after delivery?

i. Grand Mal seizures **YES / NO**

ii. Unexplained coma **YES / NO**

iii. Proteinuria **YES / NO**

iv. Oedema **YES / NO**

4. Postpartum Hemorrhage Requiring Hysterectomy

(a) Was the ongoing bleeding caused by any of the following:

i. Unresponsive and atonic uterus **YES / NO**

ii. Ruptured uterus **YES / NO**

iii. Large cervical laceration extending into the uterus **YES / NO**

5. Acute Fatty Liver of Pregnancy

(a) Was the condition unique to pregnancy? **YES / NO**

If no, please clarify:

i. Details of the existing liver disease.

_____

ii. Was there any prior history of liver dysfunction? **YES / NO**

(b) Was there micro vesicular fatty infiltration of the liver leading to fulminant hepatic failure? **YES / NO**

(c) Was the condition defined as the acute onset of encephalopathy? **YES / NO**

If yes, was it within eight (8) weeks of diagnosis of liver disease? **YES / NO**

6. Disseminated Intravascular Coagulation (D.I.C.)

(a) Was the diagnosis confirmed in accordance with the International Society on Thrombosis and Haemostasias scoring system? **YES / NO**

(b) Has the condition resulted in any of the complications below:

i. Microvascular thrombosis **YES / NO**

ii. Consumption of platelets and coagulation factors **YES / NO**

iii. Major hemorrhage **YES / NO**

7. Inpatient Psychiatric Treatment

(a) Was patient diagnosed with peripartum psychosis as per the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria? **YES / NO**

(b) Was the admission related to any of the following?

i. Postpartum depression **YES / NO**

ii. Any other pre-existing mental disorders, bipolar disorders and schizophrenia **YES / NO**

If yes, please specify: _____

8. Post-natal Anemia

(a) Was blood transfusion required? **YES / NO**

(b) Was the Hb levels < 70 g/L? **YES / NO**

(c) Was the serum ferritin < 30 mg/L? **YES / NO**

9. Puerperal Infection and Shock

(a) Was inotropic support given? **YES / NO**

(b) Was there any of the symptoms below:

i. Hypotension **YES / NO**

ii. Tachycardia (heart rate > 100/ min) **YES / NO**

iii. Leukocytosis (WBC count > 10,000/ per cu. mm.) **YES / NO**

10. Pulmonary embolism

(a) Were there symptoms of chest pain, difficulty in breathing and palpitations? **YES / NO**

(b) Was the blood oxygen saturation < 95%? **YES / NO**

(c) Was the respiratory rate > 35 / min? **YES / NO**

(d) Was the heart rate > 100 / min? **YES / NO**

(e) Was the diagnosis supported with imaging evidence or positive D-dimer test? **YES / NO**

(If yes, please attach report.)

SECTION D : ADDITIONAL DETAILS – INFECTIOUS DISEASE

Please complete the question corresponding to the respective illness as specified below.

1. ***Severe Measles***
2. ***Severe Hand Foot Mouth Disease***
3. ***Chikungunya Fever***
4. ***Typhoid Fever***
5. ***Rabies***
6. ***Creutzfeldt-Jakob disease***
7. ***Malaria***
8. ***Severe Dengue Hemorrhagic Fever***

1. Severe Measles

(a) Has the disease resulted in any of the conditions below:

i. Pneumonia **YES / NO**

ii. Encephalitis **YES / NO**

iii. Convulsions **YES / NO**

iv. Hepatitis **YES / NO**

2. Severe Hand Foot Mouth Disease

(a) Is the disease associated with any of the conditions below:

i. Encephalitis **YES / NO**

ii. Myocarditis **YES / NO**

iii. Neurological deficit for at least thirty (30) days after the diagnosis **YES / NO**

If yes, please specify: _____

3. Chikungunya Fever

(a) Is the disease associated with any of the conditions below:

i. Myocarditis **YES / NO**

ii. Ocular disease (uveitis, retinitis) **YES / NO**

iii. Hepatitis **YES / NO**

iv. Severe bullous lesions **YES / NO**

v. Neurologic disease (M*eningoencephalitis, Guillain-Barré syndrome, myelitis or cranial nerve palsies*) **YES / NO**

4. Typhoid Fever

(a) Is the disease associated with any of the conditions below:

i. Internal bleeding **YES / NO**

ii. Intestinal perforation **YES / NO**

iii. Severe neuropsychiatric symptoms (*delirium or psychosis*) **YES / NO**

5. Rabies

(a) Is the disease associated with signs and symptoms below:

i. Muscle fasciculations **YES / NO**

ii. Delirium **YES / NO**

iii. Psychosis **YES / NO**

iv. Seizures **YES / NO**

v. Aphasia **YES / NO**

6. Creutzfieldt-Jakob disease

(a) Is the disease associated with signs and symptoms below:

i. Uncontrolled muscular spasm or tremor **YES / NO**

ii. Severe progressive dementia **YES / NO**

iii. Cerebellar dysfunction **YES / NO**

iv. Athetosis **YES / NO**

7. Malaria

(a) Was the disease confirmed with light microscopy? **YES / NO**

If yes, kindly provide result: _____ parasites/mL of blood

8. Severe Dengue Hemorrhagic Fever

(a) Is there an evidence of Dengue Shock Syndrome? **YES / NO**

(b) What is the stage of Dengue Hemorrhagic Fever based on the World Health Organization case definition?

(Grade I - IV): _____

SECTION E : ADDITIONAL DETAILS - PSYCHOTHERAPY TREATMENT

Please complete this portion if the diagnosis established falls under the below description.

- ***Major Depressive Disorders (MDD)***
- ***Generalised Anxiety Disorders (GAD)***

1. Were there any signs and symptoms below?

☐ Sleep disturbances	☐ Excessive anxiety
☐ Restlessness	☐ Sad, empty or irritable mood
☐ Muscle tension	☐ Loss of interest
☐ Gastrointestinal symptoms	☐ Significant distress or impairment in social, occupational or other important areas
☐ Chronic headaches	
☐ **None of the above**	

2. Was the diagnosis confirmed based on DSM-5 criteria? **YES / NO**
Please substantiate.

_____

_____

3. Was the patient under medication prescribed for **at least six (6) continuous months?** **YES / NO**
If no, please clarify.

_____

_____
(Please attach prescription slip.)

4. Was the condition due to any of the following *(Please tick [√] in the appropriate box)*:
   - ☐ Physiological effects
   - ☐ Substance abuse
   - ☐ Another mental health condition. If yes, please specify: _____

SECTION F : OTHER INFORMATION

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 known to you.

_____

_____

3. Was the patient suffering from any of the following comorbidities? *(Please tick [√] in the appropriate box.)*
   ☐ Hypertension ☐ Diabetes Mellitus ☐ Hyperlipidaemia
   ☐ Others, kindly specify: _____

Kindly provide details:

Date	Diagnosis	Treatment	Doctor/Hospital

4. 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.

_____

_____

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

_____

_____

6. 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

7. 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 Stamp

_____
Hospital/Clinic Stamp