



\* S U P D O C \*



**Living Benefit Claim - Doctor's Statement**  
**Congenital Illnesses Benefit – Spina Bifida**

**SECTION 2 – DOCTOR'S STATEMENT** (to be completed by the attending doctor at claimant's expense)

<b>A) Patient's Particulars</b>																	
Name of Patient	Gender																
NRIC/FIN or Passport No.	Date of Birth (ddmm/yyyy) <table border="1" style="width: 100%;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>																
<b>B) Patient's Medical Records</b>																	
1) Please state over what period does the Hospital/Clinic's record extend?																	
(i) Date of first consultation (ddmm/yyyy)	<table border="1" style="width: 100%;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>																
(ii) Date of last consultation (ddmm/yyyy)	<table border="1" style="width: 100%;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>																
(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?	<input type="checkbox"/> Yes <input type="checkbox"/> No																
If "Yes", since when? (ddmm/yyyy)	<table border="1" style="width: 100%;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>																
If "No", please provide name and address of the patient's regular doctor.																	
3) Was the patient referred to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No																
If "Yes", please provide:																	
(i) Date referred (ddmm/yyyy)	<table border="1" style="width: 100%;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>																
(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?	<input type="checkbox"/> Yes <input type="checkbox"/> No																
(i) Date referred (ddmm/yyyy)	<table border="1" style="width: 100%;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>																
(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, any illness or any congenital condition? If "Yes", please provide:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Details of symptoms</u> <u>Exact diagnosis</u> <u>Date diagnosed</u> <u>Treatment</u>		
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?		
<b>C) Details of Illness</b>		
1) Please provide details of <b>Spina Bifida</b> condition.		
(i) Date the patient First consulted you for this condition (ddmm/yyyy)	<input type="text"/>	
(ii) Details of symptom(s) presented at first consultation, and date these symptoms <b>first</b> started.		
(iii) Exact Diagnosis of the condition:		
ICD-10 Code (if applicable):		
(iv) Date of <b>First</b> diagnosis (ddmm/yyyy)	<input type="text"/>	
(v) Date the patient <b>First</b> became aware of this condition (ddmm/yyyy)	<input type="text"/>	
2) Has there been defective closure of the bone encasement of the spinal cord?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3) Was the condition associated with meningeal cyst (meningocele) or meningomyelocele or myelocele? <input type="checkbox"/> Yes <input type="checkbox"/> No		
4) What is the underlying cause(s) of the condition?		
5) Was this pregnancy conceived through any of the following fertility treatments:		
(a) Vitro Fertilization ( <b>IVF</b> )	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(b) Intra-Cytoplasmic Sperm ( <b>ICSI</b> )	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(c) Intrauterine Insemination ( <b>IUI</b> )	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(d) Intracervical Insemination ( <b>ICI</b> )	<input type="checkbox"/> Yes	<input type="checkbox"/> No
(e) If none of the above, please specify the fertility treatment that the patient has received:		
6) Was the patient's mother carrying 5 or more babies in this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "No", please state the <b>number</b> of babies that the patient has carried in this single pregnancy.		

7) Is the diagnosis related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? If "Yes", please provide the date of HIV/AIDS diagnosis. (dd/mm/yyyy)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
[8 empty boxes for date]		
8) Is the diagnosis related to self-inflicted injury, suicide or attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9) Is the diagnosis related to any deliberate misuse of any drugs or alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10) Is the diagnosis related to the use of unprescribed drugs where such drugs are required by the law to be prescribed by a registered medical doctor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11) Please enclose a copy of all reports including specialist or hospital reports, laboratory evidence, surgical report, etc.		

**D) Declaration**

I hereby declare that the above answers are true to the best of my knowledge and belief.

Signature of Doctor	Address & Official Stamp of Doctor
Name of Doctor	
Date (ddmm/yyyy)	