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Attending Physician Statement - Motor Neuron Disease

Instruction to doctor: This patient is insured with us against the happening of certain contingent events associated with his health. A claim has been submitted in connection with Motor Neuron Disease. To enable us to assess the claim, please complete this report and return it directly to our company. For questions where date is applicable, please complete in the format of day/month/year.

To be completed and signed by the Attending Physician

I hereby certify that I personally examined the patient and my records and medical opinion are as follows:

1. Name of patient : ________________________________ NRIC no. : _________________

2. Are you the patient's regular medical attendant? ☐ Yes ☐ No
If yes, please provide details beginning with the first record in your clinic:

Date(s) consulted	Purpose & details of Consultation(s)	Diagnosis	Nature of treatment rendered, including type of tests and/or surgeries done

If no, do you know the name and address of the patient's regular medical attendant(s)? ☐ Yes ☐ No

If yes, please provide details:

Name of medical attendant	Address

3. Details of the consultation

3.1 Date you were first consulted for motor neuron disease: ______________________________

3.2 State the symptoms presented, the medical history as presented by the patient and date when the symptoms first appeared.

Symptoms Presented at first consultation	Date symptoms first started

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3.3 Where is the source of this information about the patient's condition? (Patient or referring doctor or others. If others, please specify)

____

3.4 In your opinion, how long do you think the symptoms first appeared prior to consulting you?

____

3.5 If the patient was referred to you OR if the patient had seen other doctor(s) before consulting you for this medical condition or its symptoms, please provide details:

Name of doctor(s) or hospital(s)	Address of doctor(s) or hospital(s)	Date consulted or date referred to you

(Please continue with your documentation on a blank page if there are more than 3 records and attached it with this report)

4. Details of the illness

4.1 Details of diagnosis:

Doctor's diagnosis	
Diagnosis date	
Underlying cause	

4.2 Date of when patient was first informed of the diagnosis: ____________________________

4.3 Name of doctor or hospital who first made the diagnosis:

____

4.4 Please specify the cause of the patient's condition.

____

4.5 Was there any progressive degeneration of the following?

(a) Coricospinal tracts ☐ Yes ☐ No

(b) Anterior horn cells ☐ Yes ☐ No

(c) Bulbar efferent neurones ☐ Yes ☐ No

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4.6 Has the patient's condition resulted in the following?

(a) Spinal muscular atrophy ☐ Yes ☐ No

(b) Progressive bulbar palsy ☐ Yes ☐ No

(c) Amytrophic lateral sclerosis ☐ Yes ☐ No

(d) Primary lateral sclerosis ☐ Yes ☐ No

4.7 If you have answer "Yes" to Q4.5 and Q4.6, please provide details and state the tests performed

____

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4.8 Does patient has Peripheral neuropathy? ☐ Yes ☐ No

(a) Has patient's peripheral neuropathy resulting in the following?

(i) Motor weakness ☐ Yes ☐ No

(ii) Fasciculation ☐ Yes ☐ No

(iii) Muscle wasting ☐ Yes ☐ No

(b) What is the underlying cause of patient's neuropathy?

____

4.9 Does the patient have full power of all limbs? ☐ Yes ☐ No

If no, please state which limb(s) do not have full power and state the current power of the affected limbs.

____

4.10 What is the current state of mobility of the patient?

(i) Ambulating without aid ❑

(ii) Confined to hospital ❑

(iii) Confined to home ❑

(iv) Confined to bed ❑

(v) Ambulating with aid ❑

(vi) Confined to wheelchair ❑

If you have answer "Yes' to Question 4.9(v) to (vi), does patient requires permanent need for the use of walking aids or a wheelchair

4.11 Please describe the type and extent of the neurological deficits presented by the patient and the dates of their onset.

Neurological limitations/deficits	Date of onset

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4.12 Please state the progress of the neurological deficits at subsequent review dates.

Neurological limitations/deficits	Date of assessment/review

4.13 Is the patient's motor neuron disease progressive? ☐ Yes ☐ No
If yes, please state your findings and the result of the tests performed to arrive at this conclusion.

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4.14 Is this neurological deficit likely to be permanent? ☐ Yes ☐ No
If yes, please state your findings and the result of the tests performed to arrive at this conclusion.

____

4.15 Was the diagnosis of motor neuron disease supported by histological, radiological, imaging or laboratory evidence and confirmed by a neurologist? ☐ Yes ☐ No

(a) If yes, please state mode of investigation done to establish the above diagnosis or surgery and attach copies of electromyogram, nerve conduction studies, CT scan, MRI, biopsy, blood test, laboratory results, operation reports and other imaging techniques.

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(b) If no, why and on what basis did you derive at such diagnosis?

____

4.16 Is the patient's condition in any way related or due to:

(a) AIDS or HIV related illness? ☐ Yes ☐ No
(b) Use of drug not prescribed by a registered medical practitioner or drug abuse? ☐ Yes ☐ No
(c) Alcohol abuse? ☐ Yes ☐ No

If yes, please provide details and enclose a copy of the test result:

Diagnosis date	
Name and address of doctor who first diagnosed the patient with the above conditions	

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5. Details of treatment and surgery

5.1 State the full details of all treatment provided (example medication, therapy).

Nature of treatment	Date(s) of treatment

5.2 Was there any surgery performed or going to be performed? ☐ Yes ☐ No
If yes, please provide details and enclose a copy of the operation report.

Nature of surgery performed or going to be performed	Date(s) of surgery

5.3 Patient's response to the treatment: ____

5.4 Was the patient referred to other doctor(s) for follow up or further management? ☐ Yes ☐ No
If yes, please state name and address of doctor(s) or hospital(s) and the reason(s) for referral.
____

5.5 Is the patient still on follow up treatment with you? ☐ Yes ☐ No
If yes, please state the follow up treatment plan.
____

6. Regarding the patient's medical history

6.1 Has this patient *previously* suffered from the same condition or any related illnesses? ☐ Yes ☐ No
If yes, please provide details:

Date of when condition was first diagnosed	
Resulting diagnosis	
Name and address of doctor who attended to patient (if not attended to by you).	

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6.2 Is the patient suffering from or suffered from any other medical conditions? ☐ Yes ☐ No
If yes, please provide details:

Name of doctor(s) or hospital(s) & Address	Diagnosis	Diagnosis date	Nature of treatment rendered, including type of tests and/or surgeries done

(Please continue with your documentation on a blank page if there are more than 3 records and attached it with this report)

6.3 Is there anything in the patient's personal medical history which would have increased the risk of motor neuron disease? ☐ Yes ☐ No
If yes, please provide full details, including the date of diagnosis, name and address of attending doctor and source of information.

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6.4 Is there anything in the patient's family history which would have increased the risk of risk of motor neuron disease? ☐ Yes ☐ No
If yes, please provide full details, including relationship, nature of illness, date of diagnosis and source of information.

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6.5 Please provide details of the patient's habits in relation to cigarette smoking, including the duration of the smoking habit, number of cigarettes smoked per day and source of information.

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6.6 Please provide details of the patient's habits in relation to alcohol consumption, including the amount of alcohol consumption per day and source of information.

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7. Please provide us with any other additional information that will enable us in assessing this claim.

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____________________________________ Date

______________________________ Name and signature of doctor

______________________________ Address and official stamp

____________________________________ Qualifications