HSBC Life

# Attending Physician Statement - Muscular Dystrophy

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 Muscular Dystrophy. 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 |
|---|---|---|---|
| | | | |
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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 muscular dystrophy: _____

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 Are there signs of progressive degeneration of the muscle characterised by weakness and atrophy of muscle? ☐ Yes ☐ No
If yes, please provide details for the basis of such conclusive diagnosis.

_____

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4.6 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 |
|---|---|
| | |
| | |
| | |

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

| Neurological limitations/deficits | Date of assessment/review |
|---|---|
| | |
| | |
| | |

4.8 Given the Activities of Daily Living (ADL) definitions stated below, please confirm which of the following activities the patient is currently ABLE to perform (whether aided or unaided):

(a) Washing/Bathing– the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means? ☐ Yes ☐ No
If yes, please state whether any assistance is required to perform Washing/Bathing and the extent of such assistance required by the patient.

_____

If no, please state why the patient cannot perform Washing/Bathing despite assistance is given and for how long (in weeks or months) since the patient became unable to perform Washing/Bathing.

_____

(b) Dressing– the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances? ☐ Yes ☐ No
If yes, please state whether any assistance is required to perform Dressing and the extent of such assistance required by the patient.

_____

If no, please state why the patient cannot perform Dressing despite assistance is given and for how long (in weeks or months) since the patient became unable to perform Dressing.

_____

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(c) Transferring– the ability to move from a bed to an upright chair or wheelchair and vice versa? ☐ Yes ☐ No

If yes, please state whether any assistance is required to perform Transferring and the extent of such assistance required by the patient.

_____

If no, please state why the patient cannot perform Transferring despite assistance is given and for how long (in weeks or months) since the patient became unable to perform Transferring.

_____

(d) Mobility– the ability to move indoors from room to room on level surfaces?

☐ Yes ☐ No

If yes, please state whether any assistance is required to perform Mobility and the extent of such assistance required by the patient.

_____

If no, please state why the patient cannot perform Mobility despite assistance is given and for how long (in weeks or months) since the patient became unable to perform Mobility.

_____

(e) Toileting– the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene? ☐ Yes ☐ No

If yes, please state whether any assistance is required to perform Toileting and the extent of such assistance required by the patient.

_____

If no, please state why the patient cannot perform Toileting despite assistance is given and for how long (in weeks or months) since the patient became unable to perform Toileting.

_____

(f) Feeding– the ability to feed oneself once food has been prepared and made available?

☐ Yes ☐ No

If yes, please state whether any assistance is required to perform Feeding and the extent of such assistance required by the patient.

_____

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If no, please state why the patient cannot perform Feeding despite assistance is given and for how long (in weeks or months) since the patient became unable to perform Feeding.

_____

4.9 Was the diagnosis of muscular dystrophy 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, muscle biopsy, CT scan, MRI, biopsy, serum creatinine, phosphokinace, laboratory results, operation reports and other imaging techniques.

_____

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

_____

4.10 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 | |

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 |
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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). | |

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 |
|---|---|---|---|
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(Please continue with your documentation on a blank page if there are more than 4 records and attached it with this report)

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

_____

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

_____

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.

_____

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.

_____

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

_____

_____ _____
Date Name and signature of doctor

_____ _____
Address and official stamp Qualifications