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PART II – ATTENDING PHYSICIAN'S STATEMENT (STATEMENT OF CRITICAL ILLNESS)

MULTIPLE SCLEROSIS / POLIOMYELITIS

This report is to be completed by a registered medical practitioner at the own expense of claimant.

Name of Patient			
Age		NRIC (New)	
Present Occupation		Gender	Male / Female

	Please tick (√) in the relevant box	Sections to be completed
	Multiple Sclerosis	1, 2, 3, 5, 6 & 7
	Poliomyelitis	1, 2, 4, 5, 6 & 7

1. General Details	
a) Are you the patient's regular medical attendant?	☐ Yes ☐
b) When did your patient first consult you for this condition?	
c) Symptoms presented at that time	
d) Date of symptoms first appeared	According to patient :______________________________________ In your opinion :______________________________________
e) Please describe the exact details of your patient's present condition.	
f) Date last seen by you	

2. Diagnosis Details	
a) Please give full details of the diagnosis.	
b) Date of diagnosis	
c) Name and address of doctor who established the diagnosis	

d) Was your patient informed of the diagnosis? If yes, when and by whom?	
e) Had your patient suffered any previous episodes of this condition or any other conditions leading to it or relating to it? If yes, please give details.	
f) Was your patient referred to you? If yes, please give name and address of doctor concerned.	
g) Name and address of doctor(s) who attended to your patient prior seeing you	
h) Name and address of doctor(s) concurrently treating your patient with you for this condition	
i) Was your patient referred to any other doctor(s) by yourself? Please give name and address of the doctor(s).	

3. Please complete the section below if your patient was diagnosed to have Multiple Sclerosis.	
a) Was there a history of repeated relapse and remission of steady progressive disability?	☐ Yes ☐ No
b) Were there lesions producing well-defined neurological deficits involving the optic nerves, brain stem and spinal cord? If yes, please give details.	☐ Yes , Details: ☐ No
c) Were there signs and symptoms of multiple or discrete lesions? Please elaborate.	
d) Date of returned to normal activities and or your patient's present limitation, physical and mental.	
e) Was the multiple neurological deficits resulting in impairment of motor and sensory functions occurring over a continuous period of six (6) months? If yes, since when?	☐ Yes , Since when: ☐ No

4. Please complete the section below if your patient was diagnosed to have Poliomyelitis.	
a) Please give details of neurological deficit e.g. paralysis or asymmetrical paralysis.	
b) Does your patient suffer from impaired motor function or respiratory weakness?	☐ Yes ☐ No

5. Have any other investigative tests or procedures been performed? If yes, please give details and enclose a copy of the report.

6. Has the patient been treated for any of the following illnesses? If yes, please provide additional information as per the table below.

	Date of diagnosis/ Onset	Name and address of Doctor(s) consulted	Dates of consultation
Hypertension			
Diabetes Mellitus			
Cardiovascular Diseases			
Other illnesses/ Injuries Please specify			

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

Note: Please enclose copies of all investigative reports including biopsy, cytology reports, CT Scans, imaging studies, laboratory evidence, surgical reports and all other relevant hospital reports that are available.

I hereby certify that I *have / have not seen the claimant's Identity Card number as stated above and that the photograph of which bears resemblance to the claimant whom I have examined.

I hereby certify that the answers above are full, complete and true.

____
(Signature of Doctor)

Name : _______________________________________

Qualification : _______________________________________

Date : _______________________________________

Official Hospital Stamp: