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

MAJOR HEAD TRAUMA

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

1. General Details	
a) Are you the patient's regular medical attendant?	☐ Yes ☐ No
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 I	
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, including exact date of episodes or conditions.	
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 to seeing you	
h) Name and address of doctor(s) who is/are treating your patient concurrently for this condition	
i) Did you refer your patient to any other doctor(s)? If yes, please provide name and address of the doctor(s).	

3. Diagnosis Details II	
a) Was a skull fracture, brain damage or cerebral contusion evident? If yes, please give details.	☐ Yes Details : ☐ No
b) Was a brain CT Scan or MRI Scan performed? If yes, please give details.	☐ Yes Details : ☐ No
c) Was there permanent neurological deficit causing significant functional impairment? If yes, please give details.	☐ Yes Details : ☐ No
d) Was the neurological deficit likely to be permanent?	☐ Yes ☐ No

4. a) Please complete the section below if your patient was diagnosed to have Loss of Independent Existence.

Please grade your patient's ability to perform the following Activities of Daily Living (ADL).

☐ 1 Complete functional limitation in performing the ADL as described.

☐ 2 Substantial limitation in performing the ADL as described.

☐ 3 Minor limitation in performing the ADL. Assistance required on an intermittent basis or with some minor part of the activity or able to perform the ADL with the use of an aid or appliance

☐ 4 No functional limitation. Able to perform the ADL independently.

Activities of Daily Living (ADL)	Date of assessment : ☐ Please tick (√) the relevant box.
i) Transfer Getting in and out of a chair without requiring physical assistance.	1 ☐ 2 ☐ 3 ☐ 4 ☐
ii) Mobility The ability to move from room to room without requiring any physical assistance.	1 ☐ 2 ☐ 3 ☐ 4 ☐
iii) Continence The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene.	1 ☐ 2 ☐ 3 ☐ 4 ☐
iv) Dressing Putting on and taking off all necessary items of clothing without requiring assistance of another person.	1 ☐ 2 ☐ 3 ☐ 4 ☐
v) Bathing / Washing The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means.	1 ☐ 2 ☐ 3 ☐ 4 ☐
vi) Eating All tasks of getting food into the body once it has been prepared.	1 ☐ 2 ☐ 3 ☐ 4 ☐

5. Have any other investigation tests or procedures been performed? If yes, please provide us the 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 investigation 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: