

VITAL CARE CLAIM – DOCTOR’S STATEMENT

Note: This form is to be completed at the Patient’s expenses by the Attending Doctor.

Patient’s Personal Details	
Name: _____	Certificate Number: _____
NRIC/Old IC/Passport/Birth Cert/Other: _____	Date of Birth: _____ Gender: _____ Male _____ Female
The claim is being filled for the following illness: (Please tick [v] in the appropriate box)	
Sections to be completed: <input type="checkbox"/> Severe Epilepsy A, B & L <input type="checkbox"/> Glomerulonephritis with Nephrotic Syndrome A, C & L <input type="checkbox"/> Rheumatic Fever with Valvular Impairment A, D & L <input type="checkbox"/> Severe Juvenile Rheumatoid Arthritis A, E & L <input type="checkbox"/> Kawasaki Disease with Heart Complications A, F & L	Sections to be completed: <input type="checkbox"/> Severe Asthma A, G & L <input type="checkbox"/> Insulin-Dependent Diabetes Mellitus A, H & L <input type="checkbox"/> Intellectual Impairment due to Illness or Accident A, I & L <input type="checkbox"/> Leukemia A, J & L <input type="checkbox"/> Severe Haemophilia A and B A, K & L
<i>Note: Assessment of claims and provision of benefits will be based on the Certificate mentioned in the form.</i>	
SECTION A: Medical History of The Patient	
1. Are you the patient’s usual Medical Attendant? <input type="checkbox"/> YES <input type="checkbox"/> NO	
2. Over what period do your record extend? a) First consultation ____ Day ____ Month ____ Year b) Last consultation ____ Day ____ Month ____ Year	
3. What were the symptoms presented when you first attended the patient? How long has the patient been experiencing the symptoms when you first saw the patient?	
Symptom(s)	Duration of Symptom(s)
4. Please describe what is the exact full diagnosis.	
Diagnosis	Diagnosis Date (DD/MM/YYYY)
5. Has the patient previously suffered from the condition specified above or any possible related illness? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If Yes, please provide the full and exact details of diagnosis.	
Diagnosis Date (DD/MM/YYYY)	Diagnosis
6. Is the condition above related directly or indirectly to any congenital/inherited disorders? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If Yes, please provide details.	
7. Was the HIV test done? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If Yes, please provide dates and results of all HIV antibody tests done and enclosed copy(s) of relevant laboratory reports.	
Date (DD/MM/YYYY)	Test Result

8. Does the patient have any personal history of any other medical or psychiatric condition?
 YES NO

If Yes, please provide details as per below:

Nature of Condition	Date of Onset (DD/MM/YYYY)	Treatment Received	Current Status of the Condition

9. Please provide details of names, addresses and qualification of all doctors, hospitals or clinics the patient has been referred or attended to for this condition.

Name	Qualification	Address of Doctor/Clinic/Hospital

SECTION B: Severe Epilepsy

1. Please provide details of the diagnosis of Severe Epilepsy.

2. Has the patient experienced unprovoked Tonic-Clonic or Grand Mal seizures?
 YES NO

If Yes, please list down the dates and duration of all attacks in last 12 months.
 Please enclose copy(s) of EEG report demonstrating the seizure attack(s).

3. Is there any known underlying cause of the seizure/epilepsy?
 YES NO

If Yes, please provide the details.

4. Has the patient undergone neurosurgery for treatment of epileptic seizure?
 YES NO

If Yes, please provide details of the surgery.

Date (DD/MM/YYYY)	Details of Surgery

5. Is the patient taking prescribed anti-epileptic (anti-convulsant) medication?
 YES NO

If Yes, please provide details as per below

Name of Medication	Date of First Prescribed (DD/MM/YYYY)	Dosage Prescribed	Duration of Medication Taken

6. If there is any further information which, in your opinion, will assist the Company in assessing the claim, please provide details.

SECTION C: Glomerulonephritis with Nephrotic Syndrome

1. Please enclose copies of reports of the relevant laboratory (i.e. Blood and urine) tests done (e.g. FBC, RFT, Inflammatory markers).
2. Please describe the treatment regimen prescribed to the patient.

Treatment Prescribed	Period of Treatment Prescribed	Purpose of the Treatment Prescribed

3. Has the patient been following the course of treatment as per above?
 YES NO

If No, kindly elaborate further.

4. If there is any further information which, in your opinion, will assist the Company in assessing the claim, please provide details.

SECTION D: Rheumatic Fever with Impairment

1. Please tick [v] the relevant options on the Revised Jones criteria.

- Carditis
- Arthritis (Mono/Poly)
- Chorea
- Erythema Marginatum
- Subcutaneous Nodule
- Fever (i.e. >38°C)
- Raised Inflammatory markers (e.g. ESR/CRP)

2. Please provide details with supporting evidence of any streptococcus infection detected.

3. Is there any heart valve(s) defect resulting from the Rheumatic Fever?
 YES NO

If Yes, please state valve(s) involved with details of incompetence.

Please enclose copy(s) of quantitative investigation (i.e. echocardiogram) on the impaired heart valve function.

Heart Valve(s)	Degree of Defect(s)

4. Please provide details of the cause of the heart valve(s) defects.

5. If there is any further information which, in your opinion, will assist the Company in assessing the claim, please provide details.

SECTION E: Severe Juvenile Rheumatoid Arthritis

1. Please provide the values of the listed component in the blood tests as per below:
Please enclose copies of the relevant blood tests (e.g. Rheumatoid Factor, Inflammatory markers, FBC) done.
- a) Rheumatoid Factor _____
 - b) Inflammatory Marker (please specify which markers) _____
2. Is there any widespread joint destruction AND major clinical deformity seen at the joints listed below? Please enclose copy(s) of the relevant imaging(s) done which demonstrating the joints destruction.
 YES NO

If Yes, kindly provide the details;

- a) Hands _____
- b) Wrists _____
- c) Elbows _____
- d) Hips _____
- e) Ankles _____
- f) Cervical Spine _____
- g) Metatarsophalangeal joints _____

3. Did the symptoms mentioned in Question 2 persisted for at least 1 year?
 YES NO

If Yes, please state the duration of the symptoms experienced by the patient.

4. If there is any further information which, in your opinion, will assist the Company in assessing the claim, please provide details.

SECTION F: Kawasaki Disease with Heart Complications

1. Please provide the details of the Kawasaki Disease.

2. Was the abnormality on the cardiac involvement manifested by dilation or aneurism formation in the coronary arteries?
 YES NO

If Yes, please provide details as per below.

Please enclose ALL copies of echocardiogram done and any other investigations performed confirming this.

Date of Onset (DD/MM/YYYY)	Details

3. If there is any further information which, in your opinion, will assist the Company in assessing the claim, please provide details.

SECTION G: Severe Asthma

1. Please provide details of the symptoms stated in Question 3 of Section A as per listed below:

- a) The onset of the symptoms
 ACUTE CHRONIC
- b) Was the patient admitted to the hospital?
 YES NO
- c) Placed on mechanical ventilation in order to control the asthma attack?
 YES NO

If Yes, please details in the corresponding table.

Date of Admissions (DD/MM/YYYY)	Name of Address of Hospital(s)	Period (Hours) on Mechanical Ventilation	Was the period continuous? (Y/N)

2. Does the patient exhibit Harrison’s Sulcus chest deformity resulted from the asthma?

- YES NO

3. Has the patient demonstrated significant growth impairment (defined as a height below 3rd percentile for child’s age & sex with asthma) from previously normal height (above 5th percentile) from the least age of 1 year old?

- YES NO

If Yes, please provide details as per below.

Please enclose copies of the Child Health Booklet which displaying the growth chart from at least 1 year old to current age.

Date of Recording (DD/MM/YYYY)	Height (cm)	Weight (kg)

4. Was the Pulmonary Function Test (Peak Expiratory Flow Rate) done?

- YES NO

If Yes, please provide details of all recordings of the patient’s peak expiratory flow rate below.

The recording must be made on at least 4 occasions at interval of no less than 1 month in a period of at least 12 months.

Please enclose copies of the patient’s Peak Flow Chart which displaying at least 4 trials within 12 months period

Date of Recording (DD/MM/YYYY)	Maximum Peak Expiratory Flow Rate	Predicted Rate for A Child of The Same Age, Sex & Build	Type of Treatment Prescribed

5. Was the patient prescribed with continuous daily use of (oral) corticosteroid to control the symptoms?

- YES NO

If Yes, please state for how long the patient had been on the medication.

6. If there is any further information which, in your opinion, will assist the Company in assessing the claim, please provide details.

SECTION H: Insulin-Dependent Diabetes Mellitus

1. Please provide the details of the diagnosis as listed below:

- a) Fasting Blood Glucose _____ mmol/L
- b) OGTT (Oral Glucose Tolerance Test) _____ mmol/L
- c) HBA1c _____ mmol/L

Please enclose copies of the relevant laboratory (i.e. Blood) tests done demonstrating the diagnosis of Insulin-Dependent Diabetes Mellitus.

2. Was the patient on exogenous insulin?

___ YES ___ NO

If Yes, please state for how long the patient has been depending on the insulin.

3. Please provide details of the insulin injection regime.

Type of Insulin	Dosage (Units/mL)	Frequency (per day)	Site(s) of Injections

4. If there is any further information which, in your opinion, will assist the Company in assessing the claim, please provide details.

SECTION I: Intellectual Impairment due to Illness or Accident

1. Please attach copy(s) of the Child Health Care Booklet displaying the routine check-up from birth to the current ones.

2. Was the impairment due to illness or accident? Kindly provide the following details according to the selected option.

___ ILLNESS (please specify)

___ ACCIDENT

- a) Date of Accident ___ Day ___ Month ___ Year
- b) Nature of Accident _____
- c) Injuries Sustained _____
- d) Hospitalization Details

Date of Admission (DD/MM/YYYY)	Name of Hospital(s)	Treatment(s) Received

___ OTHERS (please specify)

3. Is there any PERMANENT neurological impairment resulting from Question 2 at current state?
 YES NO

If Yes, please provide the following details.

a) Type of impairment

b) Details on how the diagnosis was made

4. Date when the patient and/or the patient's guardian or parent(s) first noticed the condition(s).
 Day Month Year

5. Was the IQ test/related tests done on the patient?
 YES NO

If Yes, please provide the following details. Please enclose copies of investigations performed for verification purpose.

Date (DD/MM/YYYY)	Name of the Test(s) Done	Result(s)

6. If there is any further information which, in your opinion, will assist the Company in assessing the claim, please provide details.

SECTION J: Leukemia

1. Was the Bone Marrow Trepine Biopsy AND Aspiration done?
 YES NO

If Yes, please attach the histopathology report(s).
 If No, please provide reason(s).

2. Was there any imaging(s) done?
 YES NO

If Yes, specify and attach all the imaging report(s).

3. What was the nature of the treatment?

Chemotherapy

Radiotherapy

Others (Please provide details of the treatment(s))

4. If there is any further information which, in your opinion, will assist the Company in assessing the claim, please provide details.

SECTION K: Severe Haemophilia A and B

1. Please select the relevant type of the Haemophilia.

Severe Haemophilia A

Severe Haemophilia B

2. Please provide the following details of the diagnosis.

Please enclose copies of the relevant laboratory (i.e. Blood) tests (i.e. Factor Assays, clotting profile) done

a) Factor(s) Level _____ IU/dL

b) Normal (Reference) Range _____ IU/dL

3. If there is any further information which, in your opinion, will assist the company in assessing the claim, please provide details.

SECTION L: Attending Doctor's Declaration

I hereby certify that:

I am the patient's attending doctor and I have personally examined and treated the patient for the illness/injuries sustained; OR

I have personally perused the patient's medical records;

and that the facts as stated above are all true to the best of my knowledge and information that I have perused.

Signature :

Date :

Name :

Professional Qualification :

MMC/Registration Number :

Name & Address of Hospital/Clinic :

Official Stamp of the Hospital/Doctor :