DOCTOR'S STATEMENT
(Alzheimer's Disease / Severe Dementia)

To be completed by the patient's attending doctor

A. Patient's particulars

Name (as shown in NRIC / Passport)	NRIC / Passport Number

B. Medical records

1. Please state the period of patient's record with the Hospital/Clinic?

   a. Date of first consultation _____(dd/mm/yyyy)

   b. Date of last consultation _____(dd/mm/yyyy)

   Please provide reason for consultations:

Consultation date	Reason for consultation

2. Are you the patient's regular doctor? ☐ Yes ☐ No

   If Yes, since when? _____(dd/mm/yyyy)

   If No, please provide the Name and Address of the patient's regular doctor (if known to you):

   _____

3. Was the patient referred to you? ☐ Yes ☐ No
   If Yes, please provide details:

Date of referral	Reason for referral	Name and Address of referring doctor

4. Have you referred the patient to other doctor/hospital/clinic? ☐ Yes ☐ No
   If Yes, please provide details:

Date of referral	Reason for referral	Name and Address of doctor referred to

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5. Does the patient have any family history? ☐ Yes ☐ No

If Yes, please provide details:

Age at onset	Relationship to the patient	Nature of Condition

6. Does the patient have any other significant health conditions, medical history or any illnesses (e.g. hypertension, diabetes, hyperlipidaemia, tumour, hepatitis etc)? ☐ Yes ☐ No

If Yes, please provide details:

Diagnosis Date	Diagnosis & Treatment	Name and address of doctor who treated patient

7. Please give details of the patient's habits in relation to cigarette smoking.

No. of years of smoking	No. of sticks per day	Source of information

8. Please give details of the patient's habit in relation to alcohol consumption.

Type	Quantity	Frequency (per week / month)	Source of Information

C. Detail of Illness/Condition

1. When did patient first consult a doctor for the condition? _____(dd/mm/yyyy)

2. Please state symptoms presented and the date symptoms first appeared:

Symptoms Presented	Date symptoms first appeared	Source of information (Patient / Referring doctor* / others*) *Please specify name and address of source*

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3. What was the underlying cause of the symptoms?

_____

_____

4. What was the exact diagnosis?

_____

_____

5. When was the date of diagnosis? _____(dd/mm/yyyy)

6. When was the diagnosis first made known to the patient? _____(dd/mm/yyyy)

7. Was the diagnosis confirmed by a medical specialist? ☐ Yes ☐ No

Please provide details of the doctor who first made the diagnosis:

Name of doctor / specialist	Address of doctor / specialist

8. Please provide details and results of all investigation / tests performed and attach a copy of them which confirmed the diagnosis:

Investigation / tests	Date (dd/mm/yyyy)	Result of investigation / tests

9. Has the patient undergone any cognitive testing (e.g. Mini Mental State Examination)? ☐ Yes ☐ No

If Yes, please provide the results and attach a copy:

Date of test performed (dd/mm/yyyy)	MMSE score / results

10. Is there evidence of deterioration or loss of intellectual capacity/cognitive function? ☐ Yes ☐ No

11. Is there abnormal behaviour resulting in significant reduction in mental and social functioning requiring the continuous supervision of patient? ☐ Yes ☐ No

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If Yes to Q10 or Q11, please provide details:

a. The extent of disease, patient's behaviour and progress of the condition since time he/she was first and last seen at Hospital/Clinic.

_____

_____

_____

b. Please provide basis of your evaluation and state the date which such continuous supervision was first required.

_____

_____

12. Was there any impairment in the following cognitive areas:

Impairment	**Date of onset**
Aphasia (language)	_____(dd/mm/yyyy)
Apraxia (motor)	_____(dd/mm/yyyy)
Agnosia (sensory)	_____(dd/mm/yyyy)
Disturbance in executive functioning (e.g. planning, organizing, attention focusing etc.)	_____(dd/mm/yyyy)

13. When was the last assessment done? _____(dd/mm/yyyy)

14. Was there evidence of cognitive impairment for at least 6 months? ☐ Yes ☐ No
If Yes, please provide details:

Type of impairment	Duration of impairment

15. Was there <u>permanent</u> clinical loss of ability to do the following:

a. Remember ☐ Yes ☐ No

b. Reason ☐ Yes ☐ No

c. Perceive, understand, express and give effect to ideas ☐ Yes ☐ No

16. Has the patient been placed on disease modifying treatment prescribed by and under continuous care of a specialist? ☐ Yes ☐ No

If Yes, please provide details:

Date treatment started (dd/mm/yyyy)	Date treatment ended (dd/mm/yyyy)	Details of treatment

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17. Was the patient's condition in any way related or due to:

a. Non-organic disease such as neurosis and/or psychiatric illnesses? ☐ Yes ☐ No

b. Alcohol abuse/misuse or related brain damage? ☐ Yes ☐ No

c. Drug abuse/misuse or related brain damage? ☐ Yes ☐ No

d. Head injury related brain damage? ☐ Yes ☐ No

e. Presence of AIDS or HIV infection? ☐ Yes ☐ No

f. Attempted suicide or self-inflicted injuries? ☐ Yes ☐ No

g. Donation of any of his/her organs? ☐ Yes ☐ No

If Yes to above, please provide details:

Diagnosis date	Diagnosis	Name and address of doctor who treated patient

D. Other Information

1. Has the patient previously suffered from condition(s) specified above or any possible related illnesses? ☐ Yes ☐ No

If Yes, please provide details:

Diagnosis date	Diagnosis	Name and address of doctor who treated patient

2. Is the patient mentally incapacitated in accordance to the Mental Capacity Act (Chapter 177A of Singapore)? ☐ Yes ☐ No

Please describe his/her mental and cognitive abilities.

_____

3. Please provide us with any other additional information that will assist us in assessing the claim.

_____

E. Medical reports

Please attach copies of the following reports:

- All diagnostic investigation including cognitive testing and imaging studies results (e.g. MMSE, CT, MRI scans etc.)
- All relevant hospital/surgical reports, laboratory and test results

F. Details of attending Doctor

Signature of attending doctor	Date (dd/mm/yyyy) _____ / _____ / _____
Name & Qualification:	Address and Official Stamp of Hospital / Clinic:

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