DOCTOR'S STATEMENT
(Benign Brain Tumour / Surgical Removal of Pituitary Tumour)

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. Please provide exact location of the tumour:
   a. Was the tumour located in the brain? ☐ Yes ☐ No
   b. Was the tumour located in the brain's meninges? ☐ Yes ☐ No
   c. Was the tumour located in the cranial nerves? ☐ Yes ☐ No
   d. Was the tumour located in a site other than above mentioned? ☐ Yes ☐ No

   If Yes, please provide details on location of tumour:

   _____

   _____

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10. Please provide tumour type:

a. Was the condition cyst(s)? ☐ Yes ☐ No

b. Was the condition abscess? ☐ Yes ☐ No

c. Was the condition angioma? ☐ Yes ☐ No

d. Was the condition granulomas? ☐ Yes ☐ No

e. Was the condition vascular malformations of the brain arteries or veins? ☐ Yes ☐ No

f. Was the condition haematomas? ☐ Yes ☐ No

g. Was the condition a tumour of pituitary gland? ☐ Yes ☐ No

h. Was the condition a tumour of spinal cord? ☐ Yes ☐ No

i. Was the condition a tumour of skull base? ☐ Yes ☐ No

11. Was the condition life-threatening? ☐ Yes ☐ No

12. Has the tumour caused any damage to the brain? ☐ Yes ☐ No
If Yes, please provide details & extent:

_____

_____

13. Has the tumour caused an increase in intracranial pressure? ☐ Yes ☐ No
If Yes, please provide details:

_____

_____

14. Has the patient undergone any surgical removal of the tumour? ☐ Yes ☐ No
If Yes, please provide details:

a. Date of surgery: _____(dd/mm/yyyy)

b. Type of surgery:

☐ Transphenoidal/Transnasal Hypophysectomy

☐ Open Craniotomy

☐ Others, please specify: _____

c. Was the tumour partially or totally removed? ☐ Partially removed ☐ Totally removed
Please provide details of histology:

_____

_____

15. If the tumour had not been removed, was it inoperable? ☐ Yes ☐ No
If Yes, please provide basis why inoperable:

_____

_____

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16. If the tumour had not been removed, did it cause neurological deficit(s)? ☐ Yes ☐ No
If Yes, please provide details of neurological deficit(s):

_____

_____

Are the neurological deficits permanent? ☐ Yes ☐ No

17. Please tick accordingly and provide details if following deficits with persistent symptoms exist:

Please tick	Symptom of dysfunction in the nervous system	Date of assessment (dd/mm/yyyy)	Body part involved	Is symptom expected to last throughout lifetime of patient?	Please elaborate with supporting evidence
	Numbness			☐ Yes ☐ No	
	Paralysis			☐ Yes ☐ No	
	Localised weakness			☐ Yes ☐ No	
	Dysarthria (difficulty with speech)			☐ Yes ☐ No	
	Aphasia (inability to speak)			☐ Yes ☐ No	
	Dysphagia (difficulty swallowing)			☐ Yes ☐ No	
	Visual impairment			☐ Yes ☐ No	
	Difficulty in walking			☐ Yes ☐ No	
	Lack of coordination			☐ Yes ☐ No	
	Tremor			☐ Yes ☐ No	
	Seizures			☐ Yes ☐ No	
	Dementia			☐ Yes ☐ No	
	Delirium			☐ Yes ☐ No	
	Coma			☐ Yes ☐ No	
	Others, please specify:			☐ Yes ☐ No	

18. If the benign brain tumour is operable but not been removed, was the patient on schedule for operation to remove the tumour? ☐ Yes ☐ No

If Yes, please provide schedule date of operation: _____(dd/mm/yyyy)

If No, please provide reason:

_____

_____

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

a. Alcohol abuse/misuse? ☐ Yes ☐ No

b. Drug abuse/misuse or use of drug not prescribed by registered medical practitioner? ☐ Yes ☐ No

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

d. Congenital anomaly or defect? ☐ Yes ☐ No

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

f. 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 imaging studies results (e.g. 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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