DOCTOR'S STATEMENT
(Blindness / Loss of Sight in One Eye / Optic Nerve Atrophy / Corneal Transplant)

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. Was the visual loss as a result of accident? ☐ Yes ☐ No

If Yes, please provide details:

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

b. Time of accident: _____ a.m. / p.m.

c. Detail of how the accident happened:

_____

_____

_____

If No, what was the cause?

_____

_____

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10. What is the patient's current visual acuity of both eyes using Snellen Chart?

Left : _____ Right : _____

11. What is the patient's current visual field of both eyes using Snellen Chart?

Left : _____ Right : _____

12. Is the visual loss permanent and irreversible in one or both eye? ☐ Yes ☐ No
If Yes, please provide details on <u>which eye is affected</u> and support your basis:

_____

_____

13. Will any surgical procedures, implants or other means of treatment improve or could reinstate patient's vision in either or both eyes? ☐ Yes ☐ No
If Yes, please provide details:

a. Name & type of treatment:

Name of treatment	Type of treatment

b. Has above treatment been recommended to patient? ☐ Yes ☐ No
If No, please provide reason:

_____

_____

If Yes, when is the scheduled date of treatment? _____(dd/mm/yyyy)

14. 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

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This section is applicable to Optic Nerve Atrophy only.

15. Has the patient suffered from optic nerve atrophy with low vision? ☐ Yes ☐ No

If Yes, how was the diagnosis of optic nerve atrophy established?

_____

_____

_____

16. Are both eyes affected as a result of optic nerve atrophy? ☐ Yes ☐ No

17. What is the best corrected visual acuity of both eyes, using Snellen Chart?

Left : _____ Right : _____

This section is applicable to Corneal Transplant only.

18. Was the patient a recipient of a whole corneal transplant? ☐ Yes ☐ No

If Yes, please provide details:

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

b. Was the cornea transplant due to irreversible scarring with resulting reduced visual acuity which cannot be corrected with other methods? ☐ Yes ☐ No

Please provide detail for your above answer:

_____

_____

_____

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.

_____

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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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