DOCTOR'S STATEMENT
(Coma / Severe Epilepsy)
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. How was the diagnosis of Coma established?
Please attach copy of the diagnostic investigation reports (e.g. EEG, MRI, PET etc)

_____

_____

_____

10. Was there any reaction or response to external stimuli or internal needs persisting continuously with the use of life support system for:

a. At least 48 hours? ☐ Yes ☐ No

b. At least 72 hours? ☐ Yes ☐ No

c. At least 96 hours? ☐ Yes ☐ No

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If Yes to any of above, please support your basis with medical evidence:

_____

_____

If No to all of above, please state the number of hours the patient was in a state of coma with no response to external stimuli:

_____

_____

11. Was the patient put on life support measures? ☐ Yes ☐ No

If Yes, please give provide details:

a. Date the patient was put on life support measures: _____(dd/mm/yyyy)

b. Details of the life support measures:

_____

_____

12. Has the patient woken up from the state of coma? ☐ Yes ☐ No

If Yes, please provide details:

a. Date patient woke up from coma: _____(dd/mm/yyyy)

b. Time patient woke up from coma: _____ a.m. / p.m.

13. Was there any brain damage resulting in permanent neurological deficit? ☐ Yes ☐ No

If Yes, please provide details:

a. Has the neurological deficit lasted for more than 30 days from onset of coma? ☐ Yes ☐ No

b. Please provide dates and describe the neurological deficits presented:

Assessment dates (dd/mm/yyyy)	Neurological deficits presented

14. Is the patient diagnosed with Epilepsy? ☐ Yes ☐ No

If Yes, how was the diagnosis of Epilepsy established?

_____

_____

_____

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15. Has the patient experienced recurrent unprovoked tonic-clonic or grand mal seizures, and be known to be resistant to optimal therapy as confirmed by drug-serum level testing? ☐ Yes ☐ No

If Yes, please provide following:

a. Date of attacks:

_____

_____

b. Frequency of attacks per week:

_____

_____

16. Has the patient undergone any form of neuro surgery for the treatment of epileptic seizures? ☐ Yes ☐ No

If Yes, please provide date of surgery. _____(dd/mm/yyyy)

17. Is the epilepsy due to febrile seizures alone? ☐ Yes ☐ No

18. Is the epilepsy due to absence (petit mal) seizures alone? ☐ Yes ☐ No

19. Is the patient taking prescribed anti-epileptic (anti-convulsant) medication? ☐ Yes ☐ No

20. Would you consider the patient to be on optimal drug therapy? ☐ Yes ☐ No

If Yes, please state the type and period the patient has been taking the medication.

Type of each prescribed medication	Period of medication

If No, please provide details

_____

_____

21. 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

g. Medically induced coma? ☐ Yes ☐ No

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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 electroencephalography (EEG), magnetic resonance imaging (MRI), positron emission tomography (PET) 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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