DOCTOR'S STATEMENT
(Fulminant Hepatitis / Sclerosing Cholangitis / Viral Hepatitis / Biliary Tract Reconstruction Surgery)

To be completed by the patient's attending doctor

A. Patient's particulars

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

B. Patient's 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 state the type of hepatitis virus diagnosed?

_____

_____

10. When was the approximate date of commencement? _____(dd/mm/yyyy)

11. Please provide the following information in relation to patient's diagnosis of fulminant hepatitis:

a. Was a liver biopsy performed? ☐ Yes ☐ No

If Yes, please provide date of biopsy? _____(dd/mm/yyyy)
(please attach copy of result)

b. Was an abdominal ultrasound performed? ☐ Yes ☐ No

If Yes, please provide date of ultrasound? _____(dd/mm/yyyy)
(please attach copy of result)

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c. Is there submassive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure? ☐ Yes ☐ No
If Yes, please provide details:

i. Is there rapid decreasing of liver size? ☐ Yes ☐ No
If Yes, please advise state of liver and its lobular architecture:

_____

_____

ii. Is there necrosis involving entire lobules, leaving only a collapsed reticular framework? ☐ Yes ☐ No
If Yes, please advise the extent of the liver necrosis and its lobular architecture:

_____

_____

iii. Is there a rapid deterioration of liver function tests? ☐ Yes ☐ No
If Yes, please state the test results evident of the rapid deterioration and to attach a copy of the results:

_____

_____

iv. Is there deepening jaundice? ☐ Yes ☐ No
If Yes, please provide details:

_____

_____

v. Is there evidence of hepatic encephalopathy? ☐ Yes ☐ No
If Yes, please provide details including dates, underlying causes, treatment and complications (if any):

_____

_____

12. Is there submassive necrosis of the liver by the hepatitis virus leading to cirrhosis? ☐ Yes ☐ No
Please provide details:

Metavir grading	Knodell fibrosis score

13. Has the patient undergone biliary tract reconstruction surgery involving choledochoenterostomy (choledochojejunostomy or choledochoduodenostomy) for the treatment of biliary tract disease, including biliary atresia? ☐ Yes ☐ No

If Yes, please provide details:

a. Date of biliary tract reconstruction surgery? _____(dd/mm/yyyy)

b. Is the biliary tract disease not amenable by other surgical or endoscopic measures? ☐ Yes ☐ No

c. Is the surgery considered the most appropriate treatment? ☐ Yes ☐ No

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d. Is the patient's current condition a consequence of gall stone disease or cholangitis? ☐ Yes ☐ No

14. Is patient's condition of chronic primary sclerosing cholangitis confirmed by cholangiogram? ☐ Yes ☐ No

If Yes, please provide details:

a. Is there progressive obliteration of the bile ducts? ☐ Yes ☐ No

b. Is there permanent jaundice? ☐ Yes ☐ No

c. Is there a need for immunosuppressive treatment, drug therapy for intractable pruritis or if biliary tract obliteration that required balloon dilation or stenting of the bile ducts? ☐ Yes ☐ No

d. Is the patient's biliary tract sclerosis or obstruction a consequence of biliary surgery, gall stone disease, infection, cancer, inflammatory bowel disease or other secondary precipitants? ☐ Yes ☐ No

If Yes, please provide details:

_____

_____

15. What is the current condition of the patient and prognosis?

_____

_____

16. 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

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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 ultrasounds, CT/MRI scans, biopsy, operation reports etc.
- All relevant hospital/surgical, 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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