DOCTOR'S STATEMENT
(Heart Attack / Cardiac Defibrillator or Pacemaker Insertion / Pericardectomy)

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. Describe the initial episode regarding the condition:

   a. Date of initial episode _____(dd/mm/yyyy)

   b. Nature of episode

   _____

   _____

   c. Duration of acute symptoms

   _____

   _____

   d. Date of return to normal activities _____(dd/mm/yyyy)

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10. Was there evidence of death of heart muscle due to obstruction of blood flow ? ☐ Yes ☐ No

11. Was there history of typical chest pain? ☐ Yes ☐ No

12. Was there any sign of ECG changes evident of new death of heart muscle due to obstruction of blood flow? ☐ Yes ☐ No

13. Were there new ECG changes with development of ST elevation or depression? ☐ Yes ☐ No

14. Were there new ECG changes with development of T wave inversion? ☐ Yes ☐ No

15. Were there new ECG changes with development of pathological Q waves? ☐ Yes ☐ No

16. Were there new ECG changes with development of left bundle branch block? ☐ Yes ☐ No
If Yes to above Q13-16, please provide details:

Date of ECG results	Describe the ECG changes / details

17. Was there elevation of cardiac Troponin (T or I) evident of death of heart muscle due to obstruction of blood flow? ☐ Yes ☐ No
If Yes, please provide series of readings and their dates:

Date of result	Elevated Troponin (T or I) readings

If No, please provide basis to confirm the diagnosis of heart muscle death due to obstruction of blood flow without elevation in cardiac enzyme Troponin.

_____

_____

18. Was the rise in cardiac Troponin (T or I) measured at 0.5ng/ml and above? ☐ Yes ☐ No

19. Was the elevation of cardiac Troponin (T & I) following an intra-arterial cardiac procedure? ☐ Yes ☐ No
If Yes, please provide details and copy of the result:

Date of procedure	Name of procedure

20. Was the elevation of cardiac enzyme CKMB evident of death of heart muscle due to obstruction of blood flow? ☐ Yes ☐ No
If Yes, please provide series of readings and their dates:

Date of result	Elevated CKMB readings

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If No, please provide basis to confirm the diagnosis of heart muscle death due to obstruction of blood flow without elevation in cardiac enzyme CKMB.

_____

_____

21. Was the elevation of cardiac enzyme CK-MB following an intra-arterial cardiac procedure? ☐ Yes ☐ No
If Yes, please provide details and copy of the result:

Date of procedure	Name of procedure

22. Was there diagnostic elevation of any other cardiac enzymes? ☐ Yes ☐ No
If Yes, please provide details:

Type of cardiac enzymes test	Date of test	Test results

23. Was the left ventricular ejection fraction less than 50%? ☐ Yes ☐ No
If Yes, please provide details and copy of diagnostic reports:

Date of test	Test results

24. Was there imaging evidence of new loss of viable myocardium? ☐ Yes ☐ No

25. Was there imaging evidence of new regional wall motion abnormality? ☐ Yes ☐ No
If Yes to Q24 or Q25, please provide details and copy of imaging reports:

Date of Test	Test results

26. Was a cardiac pacemarker inserted? ☐ Yes ☐ No
If Yes, please provide details:
    a. Date of insertion _____(dd/mm/yyyy)
    b. Was a permanent cardiac pacemaker inserted? ☐ Yes ☐ No

27. Was a cardiac defibrillator inserted? ☐ Yes ☐ No
If Yes, please provide details:
    a. Date of insertion _____(dd/mm/yyyy)
    b. Was a permanent cardiac defibrillator inserted? ☐ Yes ☐ No

28. Was the insertion of cardiac pacemaker / cardiac defibrillator absolutely necessary? ☐ Yes ☐ No

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29. Was there any other method of treatment, other than cardiac defibrillator or cardiac pacemaker, which could have been used to treat patient's cardiac arrhythmia? ☐ Yes ☐ No
If Yes, please provide details:

Name of alternative treatment	Explain why this alternative treatment was not performed to treat patient's condition

30. Was patient diagnosed with Pericardial Disease? ☐ Yes ☐ No
If Yes, please provide details:

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

b. Was any form of surgical treatment performed to treat the condition? ☐ Yes ☐ No
If Yes, please provide details:

Surgery type	Has patient undergone this surgery	Date of surgery
Pericardectomy	☐ Yes ☐ No	
Others (please specify):	☐ Yes ☐ No	

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

_____

_____

32. 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 ECGs, Echo, cardiac enzymes CK-MB, Troponin T or I 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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