DOCTOR'S STATEMENT
(Irreversible Loss of Speech / Loss of Speech due to Vocal Cord Paralysis / Tracheostomy)

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. Date of onset when patient loses ability to speak? _____(dd/mm/yyyy)

10. Has there been any improvement in the patient's speech since onset of condition? ☐ Yes ☐ No

If No, please provide details:

_____

_____

11. Is the loss of speech a result of injury to the vocal cords? ☐ Yes ☐ No

If Yes, please provide details including dates and circumstances leading to the injury:

_____

_____

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12. Is the loss of speech a result of disease to the vocal cords? ☐ Yes ☐ No

If Yes, please provide details including symptoms, diagnosis, dates and treatments:

_____

_____

13. Is the loss of speech due to diagnosis of complete and irrecoverable paralysis of vocal cord as a consequence of neurological disease or injury? ☐ Yes ☐ No

If Yes, please details of the disease or injury:

_____

_____

14. If No to Q11 - Q13, what was the cause of the loss of speech?

_____

_____

15. Is the loss of speech total and irrecoverable / irreversible? ☐ Yes ☐ No

If Yes, please provide details to support above:

Dates (dd/mm/yyyy)	Investigation performed

Please provide copy of all diagnostic test reports performed (e.g. fiberoptic nasolaryngoscopy etc)

16. Will any surgery improve or reinstate patient's ability to speak? ☐ Yes ☐ No

If Yes, please provide details on what kind of surgery will be necessary and what is the tentative date of surgery:

_____

_____

_____

17. Did patient's inability to speak last for a continuous period of 12 months? ☐ Yes ☐ No

If Yes, please provide:

a. Date of onset _____(dd/mm/yyyy)

b. Last Date of establishment _____(dd/mm/yyyy)

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18. Were there any associated neurological or psychiatric conditions contributing to the loss of speech? ☐ Yes ☐ No

If Yes, please provide details:

Exact Diagnosis	Diagnosis Date	Name & Address of treating doctor

19. Is the patient currently undergoing any speech therapy sessions? ☐ Yes ☐ No

If Yes, please provide the frequency and duration:

_____

_____

If No, please state date of last session _____(dd/mm/yyyy)

20. Has tracheostomy been performed? ☐ Yes ☐ No

If Yes, please provide details:

a. Date tracheostomy was done: _____(dd/mm/yyyy)

b. Purpose of tracheostomy:

_____

c. Was tracheostomy performed for treatment of lung or airway disease or a ventilatory support measure following major trauma or burns? ☐ Yes ☐ No

If Yes, please provide details on why it was required:

_____

d. Was the tracheostomy tube in place and functional for a period of at least 3 months? ☐ Yes ☐ No

e. When was tracheostomy tube removed? _____(dd/mm/yyyy)

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

If Yes to above, please provide details:

Diagnosis date	Diagnosis	Name and address of doctor who treated patient

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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 clinical, radiological and histological results.
- 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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