DOCTOR'S STATEMENT
(Major / Severe Burns)

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. Has the patient been diagnosed with burn? ☐ Yes ☐ No
   If No, please provide full and final 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. Were the major/severe burns 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:

_____

_____

_____

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d. Was the accident reported to police? ☐ Yes ☐ No
If Yes, please provide details:

Name of police officer	Branch of Police Division

Please attach copy of the police report.

If No, why not:

_____

10. Is there reason to suspect that there were contributory circumstances which led to the injury e.g. under the influence of alcohol, drugs, suicide? ☐ Yes ☐ No

If Yes, please provide details (e.g. result of blood alcohol concentration, alcohol breath test, name of drugs, quantity consumed etc)

_____

_____

11. Please state the areas affected on the patient's body, the percentage of surface area, and the degree of burns in each affected area:

Areas affected	Percentage of surface area	Degree of burns

a. Please confirm if the patient suffered from burns resulting in Second Degree (partial thickness of the skin) burns covering at least 20% of the surface of his/her body? ☐ Yes ☐ No

b. Please confirm if the patient suffered from burns resulting in Third Degree (full thickness of the skin) burns covering at least 50% of his/her face? ☐ Yes ☐ No

c. Please confirm if the patient suffered from burns resulting in Third Degree (full thickness of the skin) burns covering at least 20% of the surface of his/her body? ☐ Yes ☐ No

12. Has the patient undergone any skin grafts to repair damaged skin? ☐ Yes ☐ No

If Yes, please provide date of grafting: _____(dd/mm/yyyy)

If No, please provide details on alternative treatments patient received:

_____

_____

13. What was patient's response to treatment?

_____

_____

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14. Has patient previously suffered from any prior burns or related conditions? ☐ Yes ☐ No
If Yes, please provide details including dates, type of treatment received, duration of hospitalisation, name & address of treating doctors.

_____

_____

_____

15. Please describe and provide details on the nature and severity of patient's physical and mental disability and limitation?

_____

_____

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

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 surgical skin graft report 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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