DOCTOR'S STATEMENT
(Major Head Trauma / Head Trauma Requiring Reconstructive Surgery or Open Craniotomy / Surgery for subdural haematoma)

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. Were the head trauma a result of accident? ☐ Yes ☐ No

If No, please state the cause:

_____

_____

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, fits? ☐ Yes ☐ No

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

_____

_____

11. Was the head injury due to participation or attempted participation in an unlawful act? ☐ Yes ☐ No

12. Was there any form of neurological deficit still present 6 weeks after date of accident? If Yes, please provide details of the deficits: ☐ Yes ☐ No

_____

_____

13. Is the neurological deficit likely to be permanent (i.e. lasting throughout patient's lifetime)? If Yes, please provide your basis: ☐ Yes ☐ No

_____

_____

If No, please state date of recovery or date which patient is expected to recover:

_____

_____

14. Please tick accordingly and provide details if the following neurological deficit with persistent clinical symptoms exists.

Please tick	Symptoms	Assessment date (dd/mm/yyyy)	Body part involved	Is symptom expected to be permanent?	Please elaborate with supporting evidence
	Numbness			☐ Yes ☐ No	
	Paralysis			☐ Yes ☐ No	

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Please tick	Symptoms	Date of assessment (dd/mm/yyyy)	Body part involved	Is symptom expected to be permanent?	Please elaborate with supporting evidence
	Localised weakness			☐ Yes ☐ No	
	Dysarthria (difficulty with speech)			☐ Yes ☐ No	
	Aphasia (inability to speak)			☐ Yes ☐ No	
	Dysphagia (difficulty swallowing)			☐ Yes ☐ No	
	Visual impairment			☐ Yes ☐ No	
	Difficulty in walking			☐ Yes ☐ No	
	Lack of coordination			☐ Yes ☐ No	
	Tremor			☐ Yes ☐ No	
	Seizures			☐ Yes ☐ No	
	Dementia			☐ Yes ☐ No	
	Delirium			☐ Yes ☐ No	
	Coma			☐ Yes ☐ No	
	Others, please specify:			☐ Yes ☐ No	

15. Did the patient suffer from facial injury? ☐ Yes ☐ No
    If Yes, please provide details:
    a. Date of accident resulting in facial injury? _____(dd/mm/yyyy)
    b. Detail of how the accident happened:

    _____

    _____

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c. Details of facial injury sustained:

_____

_____

d. Was there any reconstructive surgery done above the neck (restoration or re-construction of the shape of and appearance of facial structures which are defective, missing, or damaged or misshapened) to correct disfigurement as a direct result of the accident? ☐ Yes ☐ No

If Yes, please provide dates and detail of surgery performed:

_____

_____

e. Was the reconstructive surgery solely for treatment relating to teeth and/or any other dental restoration? ☐ Yes ☐ No

16. Did the patient suffer from accidental cervical spinal cord injury? ☐ Yes ☐ No

If Yes, please provide details:

a. Date of accident resulting in cervical cord injury _____(dd/mm/yyyy)

b. Detail of how the accident happened:

_____

_____

c. Details of cervical cord injury sustained:

_____

_____

d. Has the accidental cervical cord injury resulted in the loss of use of at least one (1) entire limb for at least 6 weeks from the accident? ☐ Yes ☐ No

If Yes, please provide detail on the extent and severity of the loss of use of the limb:

_____

_____

17. Did patient undergo any surgery for treatment of the head injury? ☐ Yes ☐ No

If Yes, please provide details:

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

b. Please provide of name & nature of surgery performed?

_____

c. Did patient undergo open craniotomy surgery? ☐ Yes ☐ No

d. Did patient undergo burr hole surgery to drain subdural haematoma? ☐ Yes ☐ No

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18. 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.

_____

E. Medical reports

Please attach copies of the following reports:

- All diagnostic investigation reports including X-ray, CT/MRI & imaging scans, Operation 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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