DOCTOR'S STATEMENT
(Multiple Sclerosis)

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

China Taiping Insurance (Singapore) Pte. Ltd. (Co. Reg. No. 200208384E)
3 Anson Road #16-00 Springleaf Tower Singapore 079909 6389 6111 6222 1033 www.sg.cntaiping.com

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*

China Taiping Insurance (Singapore) Pte. Ltd. (Co. Reg. No. 200208384E)
3 Anson Road #16-00 Springleaf Tower Singapore 079909 6389 6111 6222 1033 www.sg.cntaiping.com

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 neurologist? ☐ 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 describe in full details (with dates) the extent of neurological deficits?

_____

_____

_____

10. Was there any permanent residual neurological deficit occurring at 3 months after diagnosis? ☐ Yes ☐ No

If Yes, please provide details with dates:

_____

_____

11. Were there multiple neurological deficits occurring over a continuous period of at least 6 months? ☐ Yes ☐ No

China Taiping Insurance (Singapore) Pte. Ltd. (Co. Reg. No. 200208384E)
3 Anson Road #16-00 Springleaf Tower Singapore 079909 6389 6111 6222 1033 www.sg.cntaiping.com

If Yes, please provide details of each episode with dates:

_____

_____

_____

12. Is there history of exacerbations and remissions of the said symptoms or neurological deficits? ☐ Yes ☐ No
If Yes, please provide details of each episode with dates:

_____

_____

_____

13. Is patient's condition in any way related or due to:
    a. Systemic Lupus Erythematous (SLE)? ☐ Yes ☐ No
    b. Human Immunodeficiency Virus (HIV)? ☐ Yes ☐ No

If Yes to any of above, please provide details

_____

_____

_____

14. Please provide details of treatment.

Treatment Date from	Treatment Date to	Treatment

15. Has the patient returned to normal activities? ☐ Yes ☐ No

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

16. Please describe patient's mental and cognitive abilities.

_____

_____

_____

_____

China Taiping Insurance (Singapore) Pte. Ltd. (Co. Reg. No. 200208384E)
3 Anson Road #16-00 Springleaf Tower Singapore 079909 6389 6111 6222 1033 www.sg.cntaiping.com

17. Is the patient mentally incapacitated in accordance to the Mental Capacity Act (Chapter 177A of Singapore)? ☐ Yes ☐ No

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. 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 CT/MRI and other imaging studies 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:

China Taiping Insurance (Singapore) Pte. Ltd. (Co. Reg. No. 200208384E)
3 Anson Road #16-00 Springleaf Tower Singapore 079909 6389 6111 6222 1033 www.sg.cntaiping.com