DOCTOR'S STATEMENT
(Muscular Dystrophy / Spinal Cord Disease or Injury / Type 1 Juvenile Spinal Amyotrophy)

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 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. Was the diagnosis confirmed by:

a. Electromyogram? ☐ Yes ☐ No

b. Muscle biopsy? ☐ Yes ☐ No

If Yes to any of the above, please provide details:

Date of test (dd/mm/yyyy)	Result of test to support the diagnosis

If No, please provide the clinical basis to establish the diagnosis:

_____

_____

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10. What are the muscles involved?

_____

_____

11. Please describe in full details (with dates) the extent of neurological deficits?

Date of assessment	Extent of neurological deficits

12. Based on your latest record, is patient able to perform (whether aided* or unaided) the following Activities of Daily Living?

**aided shall mean the aid of special equipment, device and/or apparatus and not pertaining to human aid.*

Activity	Please tick if patient can perform the activity?	Period of inability to perform	
		From (dd/mm/yyyy)	To (dd/mm/yyyy)
Washing Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by any other means.	☐ Yes ☐ No		
Dressing Ability to put on, take off, secure and unfasten all garments and as appropriate, any braces, artificial limbs or other surgical appliances.	☐ Yes ☐ No		
Transferring Ability to move from a bed to an upright chair or wheelchair and vice versa.	☐ Yes ☐ No		
Mobility Ability to move indoors from room to room on level surfaces.	☐ Yes ☐ No		
Toileting Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.	☐ Yes ☐ No		
Feeding Ability to feed oneself once food has been prepared and made available.	☐ Yes ☐ No		

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13. Was the patient's condition spinal cord disease or chorda equina injury? ☐ Yes ☐ No

If Yes, please provide details on which area of the spine was affected:

_____

_____

_____

14. Was the spinal cord disease or chorda equina injury due to an accident? ☐ Yes ☐ No

If Yes, please provide details:

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

b. Place of accident:

_____

_____

c. Full description of how the accident happened:

_____

_____

_____

15. Has the patient's condition resulted in permanent bowel dysfunction due to spinal cord disease or chorda equina injury? ☐ Yes ☐ No

If Yes, please provide details:

a. Date patient suffered from symptom of bowel dysfunction? _____(dd/mm/yyyy)

b. Duration patient has suffered from bowel dysfunction: _____(months)

c. Clinical basis that confirmed the bowel dysfunction is permanent:

_____

_____

_____

16. Has the patient's condition resulted in permanent bladder dysfunction due to spinal cord disease or chorda equina injury? ☐ Yes ☐ No

If Yes, please provide details:

a. Date patient suffered from symptom of bladder dysfunction? _____(dd/mm/yyyy)

b. Duration patient has suffered from bladder dysfunction: _____(months)

c. Clinical basis that confirmed the bladder dysfunction is permanent:

_____

_____

_____

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17. Was permanent regular self-catheterization required? ☐ Yes ☐ No

18. Was permanent urinary conduit required? ☐ Yes ☐ No

19. Was the patient diagnosed with Type 1 Juvenile Spinal Amyotrophy? ☐ Yes ☐ No

    a. Is there progressive dysfunction of the anterior horn cells in the spinal cord and brainstem cranial nerves with profound weakness and bulbar dysfunction? ☐ Yes ☐ No

    b. Please describe in full details the extent of the condition & prognosis:

    _____

    _____

20. Please provide details of treatment.

Treatment Date from	Treatment Date to	Treatment

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

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 patient's 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 CT/MRI & 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:

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