DOCTOR'S STATEMENT
(Paralysis / Loss of Use of One Limb)

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. Was the paralysis or loss of use of limbs condition due to accident? ☐ Yes ☐ No

If No, please provide details on the underlying 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. Describe the extent and severity of injuries sustained including exact site of the body.

_____

_____

e. 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:

_____

f. Was the patient under the influence of alcohol and/or drugs at the time of accident? ☐ Yes ☐ No

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

_____

_____

g. Was the condition a result of a self-inflicted act? ☐ Yes ☐ No
If Yes, please provide details:

_____

_____

h. Did patient have any medical condition(s) that had contributed to the accident? ☐ Yes ☐ No

If Yes, please provide details:

_____

_____

10. Please state the limb(s) involved and extent of loss of use:

Limbs	Is the loss of use total and irreversible?	Please describe the extent of loss of use
Left Upper Limb	☐ Yes ☐ No	
Left Lower Limb	☐ Yes ☐ No	
Right Upper Limb	☐ Yes ☐ No	
Right Lower Limb	☐ Yes ☐ No	

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11. Please state your assessment of patient's limb power:

Assessment Date		Limb Power		Limb Power
	Left Upper Limb		Right Upper Limb	
	Left Lower Limb		Right Lower Limb	

12. Please state your assessment of patient's power grip and precision grip:

Assessment Date		Power Grip	Precision Grip
	Left Upper Limb		
	Right Upper Limb		

13. Date when loss of use of limb(s) was first diagnosed? _____(dd/mm/yyyy)

14. Date when patient was aware of loss of use of limb(s)? _____(dd/mm/yyyy)

15. Please confirm if the paralysis or loss of use of limb(s) has persisted for at least 6 weeks continuously? ☐ Yes ☐ No

    Please provide the exact date of onset: _____(dd/mm/yyyy)

16. Please confirm if the patient underwent fitting and use of prothesis to the affected limb(s)? ☐ Yes ☐ No

Affected Limb(s)	Use of prothesis	Date of fitting
Left Upper Limb	☐ Yes (above elbow) ☐ No	
Left Lower Limb	☐ Yes (above knee) ☐ No	
Right Upper Limb	☐ Yes (above elbow) ☐ No	
Right Lower Limb	☐ Yes (above knee) ☐ No	

17. Please provide details of treatment with dates, including type of operation performed, rehabilitation, physiotherapy, medication, any planned surgery etc.

Type of Treatment	From Date	To Date	Name & Address of treating doctor/hospital/clinic

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18. What was patient's response to treatment?

_____

_____

_____

19. Is patient confined to a home, hospital or other institution that provides constant care and medical attention? ☐ Yes ☐ No

If Yes, since when _____(dd/mm/yyyy)

Please provide name and address where the patient is residing now?

_____

_____

20. Based on your latest record, has the patient's condition improved, deteriorated or remained stationary, since start of condition?

_____

_____

21. Based on your opinion, do you foresee any possibility of recovery? ☐ Yes ☐ No
Please provide details to support your answer:

_____

_____

22. 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 X-rays, imaging studies, operation results 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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