# DOCTOR'S STATEMENT
## (Severe Bacterial Meningitis)

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 |
|---|---|---|
| | | |

CTPIS/LIFE/CLM-DS-BM/012024



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 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 there severe inflammation of the membranes of the brain or spinal cord? ☐ Yes ☐ No

10. Was the patient admitted to hospital due to bacterial meningitis? ☐ Yes ☐ No

    If Yes, please provide period of hospitalisation:

| Admission Dates (dd/mm/yyyy) | Discharge Dates (dd/mm/yyyy) |
|---|---|
| | |

11. Was there presence of bacterial infection in the cerebrospinal fluid (CSF) analysis? ☐ Yes ☐ No

    If Yes, please provide details:

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

    b. Findings on the analysis *(please attach copy of the result)*:

    _____



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 No, please advise on the clinical basis of the diagnosis of bacterial meningitis:

_____

_____

12. Please describe in full details (with dates) the extent of patient's current physical limitation/neurological deficits:

_____

_____

13. Please tick accordingly and provide details if the following deficit with persistent symptoms exist.

| Please tick | Symptom of dysfunction in the nervous system | Date of assessment (dd/mm/yyyy) | Body part involved | Is symptom expected to last throughout lifetime? | Please elaborate with supporting evidence |
|---|---|---|---|---|---|
| | Numbness | | | ☐ Yes ☐ No | |
| | Paralysis | | | ☐ Yes ☐ No | |
| | 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 | |



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

14. Did the neurological deficits (per Q12 & Q13) persist for a continuous period of at least six (6) weeks? ☐ Yes ☐ No

Please state the duration: _____(weeks / months)

15. Are the neurological deficits irreversible and permanent? ☐ Yes ☐ No
If Yes, please provide details of the deficits and elaborate with supporting evidence:

_____

_____

If No, please state date of recovery or date in which patient likely to recover:

_____

_____

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

| Type of Treatment | From date | To date | Name & Address of treating doctor/hospital/clinic |
|---|---|---|---|
| | | | |

17. What is the current condition of the patient and the prognosis?

_____

_____

18. Has 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 | Exact diagnosis | Name and address of doctor who treated patient |
|---|---|---|
| | | |



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

## 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 | Exact 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 biopsy & serological tests, imaging scans etc.
- All relevant hospital/surgical, laboratory and test results.

## F. Details of attending Doctor

| Signature of attending doctor | Date (dd/mm/yyyy)<br><br>_____ / _____ / _____ |
|---|---|
| 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