DOCTOR'S STATEMENT
(Severe Encephalitis)

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. Has the patient suffered from encephalitis? ☐ Yes ☐ No
   If No, please provide details on 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. What was the cause of encephalitis (e.g. viral, bacterial etc)?

_____

_____

10. Was the patient admitted to hospital due to encephalitis? ☐ Yes ☐ No
    If Yes, please provide the period of hospitalisation:

    From: _____(dd/mm/yyyy) To: _____(dd/mm/yyyy)

11. Were there neurological deficits due to encephalitis? ☐ Yes ☐ No
    If Yes, please provide details:
    a. Symptoms of the deficits:

_____

_____

_____

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b. How long had the patient suffered from the deficits? _____ (weeks)

c. Were the deficits permanent or last a lifetime? ☐ Yes ☐ No
If No, please state date of recovery or date in which likely to recover:

_____

12. Was there evidence of <u>permanent neurological deficit lasting at least 6 weeks</u> after the diagnosis date? ☐ Yes ☐ No

If Yes, please tick accordingly and provide details if the following deficit with persistent clinical symptoms exists.

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	

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

_____

_____

14. Please provide details of treatment with dates:

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

15. 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	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.

_____

_____

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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 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) _____ / _____ / _____
Name & Qualification:	Address and Official Stamp of Hospital / Clinic:

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