DOCTOR'S STATEMENT
(Stroke / Carotid Artery Surgery / Cerebral Shunt Insertion / Brain Aneurysm Surgery)

To be completed by the patient's attending doctor

A. Patient's particulars

Name (as shown in NRIC / Passport)	NRIC / Passport Number

B. 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. Describe the initial episode regarding the stroke condition:

   a. Date of initial episode _____(dd/mm/yyyy)

   b. Nature of episode

   _____

   _____

   c. Duration of acute symptoms

   _____

   _____

   d. Has there been an infarction of brain tissue, cerebral and subarachnoid haemorrhage, intracerebral embolism and/or cerebral thrombosis? ☐ Yes ☐ No

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e. Has the patient returned or is able to return to his/her normal activities? ☐ Yes ☐ No

If Yes, please state the date patient returned or is expected to return to his/her normal activities. _____(dd/mm/yyyy)

If No, please state patient's current physical and mental limitations that prevent him/her from returning to work.

Date of Assessment	Physical/Mental limitations

f. Are the investigations/findings consistent with the diagnosis of a new Stroke? ☐ Yes ☐ No
Please provide details and attach copies of all reports.

_____

10. Was there evidence of <u>permanent neurological deficit lasting at least 6 weeks</u> after the date of stroke diagnosis? ☐ 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 of patient?	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	

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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 of patient?	Please elaborate with supporting evidence
	Delirium			☐ Yes ☐ No	
	Coma			☐ Yes ☐ No	
	Others, please specify:			☐ Yes ☐ No	

11. Please provide details of treatment with dates:

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

12. Was the diagnosis of Stroke classified as any of the following:

a. Transient Ischaemic Attack? ☐ Yes ☐ No

b. Brain damage due to an accident or injury? ☐ Yes ☐ No

c. Brain damage due to an infection? ☐ Yes ☐ No

d. Brain damage due to vasculitis? ☐ Yes ☐ No

e. Brain damage due to inflammatory disease? ☐ Yes ☐ No

f. Vascular disease affecting the eye? ☐ Yes ☐ No

g. Vascular disease affecting the optic nerve? ☐ Yes ☐ No

h. Ischaemic disorders of the vestibular system? ☐ Yes ☐ No

i. Secondary hemorrhage within a pre-existing cerebral lesion? ☐ Yes ☐ No

If Yes to above, please provide details:

_____

_____

_____

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13. Has the patient's condition resulted in him/her physically or mentally disabled from ever continuing in any employment? ☐ Yes ☐ No

If Yes, please provide details:

a. What were the main physical or mental impairment and the severity of these limitations?

_____

_____

_____

b. What is your reason that the patient is incapable of any employment throughout his/her lifetime?

_____

_____

14. 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

This section is applicable to Brain Aneurysm Surgery only.

15. Has the patient undergone any Brain Aneurysm Surgery? ☐ Yes ☐ No
If Yes, please provide details:

a. Was surgery done via craniotomy? ☐ Yes ☐ No

b. Was surgery done via endovascular repair or procedure? ☐ Yes ☐ No

Date of surgery: _____(dd/mm/yyyy)

c. Was the purpose of surgery to repair intracranial aneurysm? ☐ Yes ☐ No

d. Was the purpose of surgery to remove arterio-venous malformation? ☐ Yes ☐ No

If No, please provide details of treatment and dates:

_____

_____

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16. Was an arteriography / cerebral angiogram done? ☐ Yes ☐ No
If Yes, please provide details and copy of the reports:

Date of Assessment	Findings

If No, please state any other appropriate diagnostic test that is available and provide a copy of the reports

Date of Assessment	Diagnostic Tests	Findings

This section is applicable to Cerebral Shunt Insertion only.

17. Has the patient undergone any cerebral shunt insertion? ☐ Yes ☐ No

18. Was there surgical implantation of a shunt from ventricles of the brain? ☐ Yes ☐ No
If Yes, please provide date of shunt implantation: _____(dd/mm/yyyy)

19. Was there raised pressure in the cerebrospinal fluid? ☐ Yes ☐ No
If Yes, what is/are the underlying cause(s):

_____

_____

20. Was there any intracranial pressure giving rise to neurological deficit as a result of hydrocephalus? ☐ Yes ☐ No
If Yes, please indicate the deficit(s):

_____

_____

_____

This section is applicable to Carotid Artery Surgery only.

21. Did patient suffer from narrowing of the carotid artery? ☐ Yes ☐ No
If Yes, please provide details:

Assessment date	Percentage (%) of narrowing of carotid artery

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22. Was an arteriography / angiogram done to establish the diagnosis of carotid artery stenosis? ☐ Yes ☐ No

If Yes, please provide details and copy of reports:

Date of arteriography / angiogram	Findings

If No, please state any other appropriate diagnostic test that is available and provide a copy of the reports.

Date of Assessment	Diagnostic Tests	Findings

23. Has the patient undergone any surgery for carotid artery stenosis? ☐ Yes ☐ No

If Yes, please provide details:

a. Endarterectomy of the carotid artery? ☐ Yes ☐ No

b. Percutaneous carotid angioplasty? ☐ Yes ☐ No

c. Date of surgery: _____(dd/mm/yyyy)

If No, please provide details of treatment and dates.

_____

_____

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.

_____

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E. Medical reports

Please attach copies of the following reports:

- All diagnostic investigation including CT/MRI scans and other imaging studies etc.
- All relevant hospital/surgical reports, 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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