DOCTOR'S STATEMENT
(Systemic Lupus Erythematosus with Lupus Nephritis)

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 specialist in Rheumatology/Immunology? ☐ 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. Did the patient present with the following symptoms/conditions due to Systemic Lupus Erythematosus?

a. Malar rash ☐ Yes ☐ No

b. Discoid rash ☐ Yes ☐ No

c. Photosensitivity ☐ Yes ☐ No

d. Oral ulcers ☐ Yes ☐ No

e. Arthritis ☐ Yes ☐ No

If Yes, please advise the joint(s) involved:

_____

f. Serositis ☐ Yes ☐ No

g. Renal disorder ☐ Yes ☐ No

h. Leukopenia (< 4,000/mL) ☐ Yes ☐ No

i. Lymphopenia (< 1,500/mL) ☐ Yes ☐ No

j. Haemolytic anaemia ☐ Yes ☐ No

k. Thrombocytopenia (< 100,000/mL) ☐ Yes ☐ No

If Yes to h-k, please advise the abnormal findings on the blood test:

_____

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l. Neurological disorder ☐ Yes ☐ No

If Yes, please provide details of the neurological disorder:

_____

_____

10. Was the patient tested positive for any of the following tests?

a. Anti-Nuclear Antibodies ☐ Yes ☐ No

b. L.E cells ☐ Yes ☐ No

c. Anti-DNA ☐ Yes ☐ No

d. Anti-Sm (Smith IgG Autoantibodies) ☐ Yes ☐ No

11. Are the following internal organs involved?

a. Kidneys ☐ Yes ☐ No

b. Brain ☐ Yes ☐ No

c. Heart (or pericardium) ☐ Yes ☐ No

d. Lungs (or pleura) ☐ Yes ☐ No

e. Joints with presence of polyarticular inflammatory arthritis ☐ Yes ☐ No

If Yes to any of the above, please describe the nature and extent of the impairment with dates:

_____

_____

12. Has patient's Systemic Lupus Erythematosus lead to any kidneys involvement ? ☐ Yes ☐ No

a. Was renal biopsy performed? ☐ Yes ☐ No

If Yes, please provide details on date of biopsy and the result:

_____

_____

b. Based on the biopsy results, please tick the appropriate staging of patient's condition in accordance to RPS/ISN classification of lupus nephritis:

Class	Classification	Please tick
Class I	Minimal Mesangial Lupus Nephritis	
Class II	Mesangial Proliferative Lupus Nephritis	
Class III	Focal Lupus Nephritis (active and chronic; proliferative and sclerosing)	
Class IV	Diffuse Lupus Nephritis (active and chronic; proliferative and sclerosing; segmental and global)	
Class V	Membranous Lupus Nephritis	
Class VI	Advanced Sclerosis Lupus Nephritis	

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c. Based on the biopsy results please tick the appropriate staging of patient's condition in accordance to WHO classification of lupus nephritis:

Class	Classification	Please tick
Class I	Minimal Change Lupus Nephritis	
Class II	Mesangial Lupus Glomerulonephritis	
Class III	Focal Segmental Proliferative Lupus Glomerulonephritis	
Class IV	Diffuse Proliferative Lupus Glomerulonephritis	
Class V	Membranous Lupus Glomerulonephritis	

d. Please state the creatinine clearance rate (in mL per minute)?

_____

13. Is the patient currently receiving systemic lupus immunosuppressive therapy due to involvement of multiple organs? ☐ Yes ☐ No

    a. First treatment date of immunosuppressive therapy _____(dd/mm/yyyy)

    b. Since commencement of the therapy, has the therapy lasted for a period of at least 6 months? ☐ Yes ☐ No

    If No, what is the reason that it did not persist for at least 6 months?

    _____

    _____

14. Is the patient's condition a diagnosis of discoid lupus? ☐ Yes ☐ No

15. Is the patient's condition a diagnosis involving any form of hematologic abnormalities? ☐ Yes ☐ No

16. 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 immunologic test, CT/MRI scans, biopsy, renal function test & 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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