

DOCTOR'S STATEMENT

(Acute Necrohemorrhagic Pancreatitis)

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

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*) <i>*Please specify name and address of source</i> |
|--------------------|------------------------------|--|
| | | |

3. What was the underlying cause of the symptoms?

4. Has the patient been diagnosed with Acute Necrohemorrhagic Pancreatitis? ☐ Yes ☐ No

If No, please provide the final & full 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 gastroenterology? ☐ 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 diagnosis of Acute Necrohemorrhagic Pancreatitis confirmed on histological evidence? ☐ Yes ☐ No

If Yes, please provide a copy of the histology report.

If No, please advise the clinical basis for the diagnosis of Acute Necrohemorrhagic Pancreatitis.

10. Did the patient undergo any surgical clearance of necrotic tissue or pancreatectomy ? ☐ Yes ☐ No

If Yes, please provide details:

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

- b. Nature of surgery performed. Please also provide a copy of operation report.

If No, please provide treatment details:

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

11. 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 |
|----------------|-----------|--|
| | | |

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 biopsy, scans & imaging 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: |