DOCTOR'S STATEMENT
(Progressive Supranuclear Palsy)

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. Was the patient diagnosed with progressive supranuclear palsy? ☐ 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 neurologist? ☐ 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 progressive supranuclear palsy characterized by the following:

   a. Supranuclear gaze paresis? ☐ Yes ☐ No

   b. Pseudobulbar palsy? ☐ Yes ☐ No

   c. Axial rigidity? ☐ Yes ☐ No

   d. Dementia? ☐ Yes ☐ No

10. Was the occurrence of progressive supranuclear palsy independent of all other causes? ☐ Yes ☐ No

11. Did the progressive supranuclear palsy directly resulted in lack of control of gait and balance? ☐ Yes ☐ No

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12. Did patient's condition result in permanent neurological deficit(s)? ☐ Yes ☐ No

If Yes, please provide detail:

a. Specify detail of the deficit(s) with dates:

_____

_____

_____

b. Did the neurological deficit(s) last for at least a continuous period of 6 months? ☐ Yes ☐ No

If No, please state the date patient returned or is expected to return to his/her normal activities. _____(dd/mm/yyyy)

13. Based on your latest record, is patient able to perform (whether aided* or unaided) the following Activities of Daily Living due to the above permanent neurological deficit(s)?

**aided shall mean the aid of special equipment, device and/or apparatus and not pertaining to human aid.*

Activity	Please tick if patient can perform the activity?	Period of inability to perform	
		From (dd/mm/yyyy)	To (dd/mm/yyyy)
Washing Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by any other means.	☐ Yes ☐ No		
Dressing Ability to put on, take off, secure and unfasten all garments and as appropriate, any braces, artificial limbs or other surgical appliances.	☐ Yes ☐ No		
Transferring Ability to move from a bed to an upright chair or wheelchair and vice versa.	☐ Yes ☐ No		
Mobility Ability to move indoors from room to room on level surfaces.	☐ Yes ☐ No		
Toileting Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.	☐ Yes ☐ No		
Feeding Ability to feed oneself once food has been prepared and made available.	☐ Yes ☐ No		

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14. Please provide details of treatment with dates:

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

15. 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 CT/MRI/imaging scans etc.
- All 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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