DOCTOR'S STATEMENT
(Severe Cardiomyopathy)
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 cardiomyopathy? ☐ 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 cardiologist? ☐ 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 underlying cause of patient's cardiomyopathy?

_____

_____

_____

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10. Was the cardiomyopathy characterized by impaired ventricular function of unknown aetiology? ☐ Yes ☐ No

11. Was the diagnosis of cardiomyopathy supported by echocardiographic findings of compromised ventricular performance? ☐ Yes ☐ No

    If Yes, please provide a copy of the reports.

    If No, please provide the clinical basis for the diagnosis of cardiomyopathy:

    _____

    _____

12. Has the patient's cardiomyopathy resulted in any permanent and irreversible physical impairment(s)? ☐ Yes ☐ No

    If Yes, please provide details of the impairment(s):

    _____

    _____

    _____

13. Does the patient have physical impairment which fulfills the New York Heart Association (NYHA) Classification of Cardiac Impairment? ☐ Yes ☐ No

    If Yes, please provide details:

NYHA Class	Has the patient suffered from physical impairment to following?	Is this physical impairment permanent & irreversible?
NYHA Class I: No limit of physical activity. Ordinary physical activity does not cause undue fatigue, dyspnea or anginal pain.	☐ Yes ☐ No	☐ Yes ☐ No
NYHA Class II: Slight limitation of physical activity. Ordinary physical activity results in symptoms.	☐ Yes ☐ No	☐ Yes ☐ No
NYHA Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.	☐ Yes ☐ No	☐ Yes ☐ No
NYHA Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.	☐ Yes ☐ No	☐ Yes ☐ No

14. Did the above permanent and irreversible physical impairment persisted despite at least 6 months of maximal medical therapy under the care of a cardiologist? ☐ Yes ☐ No

15. Is the patient's cardiomyopathy directly related to alcohol or drug misuse? ☐ Yes ☐ No

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If Yes, please provide details of consumption including frequency, amount/quantity, types of alcohol/drug consumed etc.

_____

_____

16. Please provide details of treatment with dates:

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

17. Was the patient's condition in any way related or due to:

a. Presence of AIDS or HIV infection? ☐ Yes ☐ No

b. Congenital anomaly or defect? ☐ Yes ☐ No

c. Attempted suicide or self-inflicted injuries? ☐ Yes ☐ No

d. 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? If Yes, please provide details: ☐ Yes ☐ No

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 cardiac CT/MRI/imaging scans, echocardiogram 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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