

## DOCTOR'S STATEMENT

(Kawasaki Disease)

To be completed by the patient's attending doctor

Α.	A. Patient's particulars							
	ame (as shown in NR		NRIC / Passport Number					
	,	1 /						
В.	3. Patient's medical records							
1.	Please state the period of patient's record with the Hospital/Clinic?							
	a. Date of first	•	(dd/mm/yyyy)					
	b. Date of last	consultation	(dd/mm/yyyy)					
	Please provide reason for consultations:  Consultation date Reason for consultation							
	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 refe	erred to you?	☐ Yes ☐ No					
	If Yes, please provide details:							
	Date of referral	Reason for referral	Name and Address of doctor referred to					
			al/clinic? ☐ Yes ☐ No					
4.	Have you referred t If Yes, please provi	he patient to other doctor/hospita de details:	Al/Clinic?					

CTPIS/LIFE/CLM-DS-KD/082024

Ago at anget	Polationship to the national		Nature of C	Condition
Age at onset	Relationship to the patient		Nature of C	ondition
	1			
	ve any other significant health	conditions, medica	al history or	any □ Yes
llnesses? f Vac. places provi	do dotailo:			
f Yes, please provi  Diagnosis Date	Diagnosis & Treatment	Name and a	dress of doc	ctor who treated patie
Diagnosis Date	Diagnosis & Heatment	Name and ac	duress or doc	ioi wilo liealeu palle
Please give details	of the patient's habits in relatio	n to cigarette smo	oking.	
No. of years of smoking	No. of sticks per day		Source of in	nformation
J				
Please give details	of the patient's habit in relatior	to alcohol consu	mption.	
Туре	Quantity	Freque (per week /		Source of Informa
etail of Illness/Co	ndition			
	ndition st consult a doctor for the cond	lition?		(dd/mm/yy
		lition? _		(dd/mm/yy
When did patient fir				
When did patient fir	st consult a doctor for the cond		So (Patient /	urce of information Referring doctor* / othe
Please state sympt	est consult a doctor for the cond	mptoms first appe	So (Patient /	
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	Vas the patient diagnosed with Kawasaki Disease?  No, please provide the final & full diagnosis:				□ Yes □ N	
When was the date of diagnosis?				(dd/mn	n/yyyy)	
When was the diagnosis first made known to the patient/family?				(dd/mi	m/yyyy	
	he diagnosis confirme e provide details of the	d by a cardiologist? e doctor who first made	e the diagnosis:		☐ Yes	□ N
	Name of doctor	' specialist	Addre	ess of doctor / spe	cialist	
Please	a provide details and	results of all investigat	tion / tests perform	ed and attach a	copy of th	nem w
confirr	e provide details and med the diagnosis: nvestigation / tests	results of all investigated Date (dd/mm/yyyy)		ed and <u>attach a</u> t of investigation /		nem w

d.	Please describe results of investigation done and <u>attach a copy</u> of the investigation that confirmed the diagnosis.					
e.	e. When was the onset of the coronary artery dilatation or aneurysm formation?				(dd/mm/yyyy)	
f.		tion or aneurys he coronary art e initial acute epi	ery(ies) pe			☐ Yes ☐ No
. Please	provide treatmer	nt details with da	ites:			
	Treatment		Dates & D treatr		Name & docto	Address of treating or/hospital/clinic
. Was th	ne patient's condit	tion in any way r	elated or du	ue to:		
a.	Alcohol abuse/n	nisuse?				☐ Yes ☐ No
b.	Drug abuse/mis medical practition		ug not pres	cribed by re	gistered	☐ Yes ☐ No
C.	Presence of AID		on?			☐ Yes ☐ No
d.	Congenital anor	maly or defect?				☐ Yes ☐ No
e.	e. Attempted suicide or self-inflict		ted injuries?			☐ Yes ☐ No
f.	Donation of any	of his/her orgar	ıs?			☐ Yes ☐ No
If Yes	es to above, please provide details:					
Dì	iagnosis date	Diagnos	sis	Name a	nd address of doc	tor who treated patient
Other In	nformation					
Has th	ne patient previou le related illnesse please provide d	s?	m condition	n(s) specifie	ed above or any	☐ Yes ☐ No
	agnosis date	Diagnosi	is	Name a	nd address of doc	tor who treated patient

2.	Is the patient mentally incapacitated in accordance to the Mental Capacity Act (Chapter 177A of Singapore)?  Please describe his/her mental and cognitive abilities.					
3.	Please provide us with any other additional inform	ation that will assist us in assessing the claim.				
E. N	Medical reports					
• /	Please attach copies of the following reports:  All diagnostic investigation including blood test, echocardiogram, cardiac catheterization etc.  All relevant hospital/surgical, laboratory and test results.					
F. [	Details of attending Doctor					
Sig	nature of attending doctor	Date (dd/mm/yyyy)				
		/				
Naı	me & Qualification:	Address and Official Stamp of Hospital / Clinic:				