DOCTOR'S STATEMENT
(Rabies)

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 doctor referred to

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? ☐ 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 Rabies? ☐ 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/family? _____(dd/mm/yyyy)

7. Was the diagnosis confirmed by a medical specialist? ☐ 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. Is the rabies disease transmitted to the patient through the bite of an infected animal? ☐ Yes ☐ No

   If Yes, please provide details:

   a. When did the event occurred? _____(dd/mm/yyyy)

   b. Please describe the event:

_____

_____

_____

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If No, please provide details on how the disease was transmitted to the patient?

_____

_____

_____

10. Is there evidence of following:

a.	Difficulty in swallowing?	☐ Yes ☐ No
b.	Excessive salivation?	☐ Yes ☐ No
c.	Fear of water (hydrophobia)?	☐ Yes ☐ No
d.	Hallucinations?	☐ Yes ☐ No
e.	Presence of rabies virus antigen?	☐ Yes ☐ No
f.	Rabies neutralizing antibody titer in the CSF?	☐ Yes ☐ No

11. Please provide treatment details with dates:

Treatment	Dates & Duration of treatment	Name & Address of treating doctor/hospital/clinic

12. 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 blood tests, serology tests 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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