# DOCTOR'S STATEMENT
## (Chronic Adrenal Insufficiency)
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 adrenal insufficiency? ☐ 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 medical specialist/endocrinologist? ☐ 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 adrenal insufficiency due to primary cause? ☐ Yes ☐ No

10. Was the adrenal insufficiency due to secondary cause? ☐ Yes ☐ No
    If Yes, please provide details:

_____

11. Was the cause of patient's condition an autoimmune disease? ☐ Yes ☐ No
    If No, please provide details of the cause:

_____

_____



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12. Was there gradual destruction of the adrenal gland? ☐ Yes ☐ No

13. Was the adrenal insufficiency condition confirmed by the following:

a. ACTH simulation tests? ☐ Yes ☐ No

b. Insulin-induced hypoglycemia test? ☐ Yes ☐ No

c. Plasma ACTH level measurement? ☐ Yes ☐ No

d. Plasma Renin Activity (PRA) level measurement? ☐ Yes ☐ No

If Yes, please provide copy of the test results.

14. Was there a need for life long glucocorticoid and mineral corticoid replacement therapy? ☐ Yes ☐ No

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.

_____



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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, imaging scans etc.
- All hospital/surgical, laboratory and test results.

## F. Details of attending Doctor

| | |
|---|---|
| Signature of attending doctor | Date (dd/mm/yyyy)<br><br>_____ / _____ / _____ |
| Name & Qualification: | Address and Official Stamp of Hospital / Clinic: |



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