DOCTOR'S STATEMENT
(Major Cancer / Carcinoma in situ / Breast Reconstructive Surgery after Mastectomy)

To be completed by the patient's attending doctor

A. Patient's particulars

Name (as shown in NRIC / Passport)	NRIC / Passport Number

B. 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 (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. What was the exact 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? ☐ 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. Please indicate the primary and exact anatomical site of tumour.

_____

_____

10. Is the tumour malignant? ☐ Yes ☐ No

a. Is there histological evidence of uncontrolled growth of malignant cells with invasion and destruction of normal tissue? ☐ Yes ☐ No

b. If histological evidence is unavailable, please advise the clinical basis on establishing the diagnosis of malignant tumour.

_____

_____

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11. What is the histological diagnosis of the condition?

_____

_____

12. What is the staging of the tumour (e.g. TNM classification, FIGO, RAI etc)?

_____

_____

a. Was the disease completely localised? ☐ Yes ☐ No

b. Was there invasion of adjacent tissues? ☐ Yes ☐ No

c. Were regional lymph nodes involved? ☐ Yes ☐ No

d. Were there distant metastases? ☐ Yes ☐ No

If Yes, please provide full details including site of metastases.

_____

13. Was the diagnosis of cancer derived based on the finding of tumour cells and/or tumour-associated molecules in blood, saliva, faeces, urine or any bodily fluid in the absence of further verifiable evidence? ☐ Yes ☐ No

14. Please confirm the histological classification of the tumour:

a. Is it non-invasive or benign? ☐ Yes ☐ No

b. Is it Pre-malignant? ☐ Yes ☐ No

c. Is it Carcinoma in situ (Tis) or Ta? ☐ Yes ☐ No

d. Is it having borderline malignancy? ☐ Yes ☐ No

e. Is it having any degree of malignant potential? ☐ Yes ☐ No

f. Is it having suspicious malignancy? ☐ Yes ☐ No

g. Is it a neoplasm of uncertain or unknown behaviour? ☐ Yes ☐ No

h. Is it any grade of cervical dysplasia, CIN 1, CIN 2 or CIN 3 (severe dysplasia without carcinoma in situ)? ☐ Yes ☐ No

i. Is it squamous intraepithelial lesions (HSIL and LSIL) or intraepithelial neoplasia? ☐ Yes ☐ No

j. Is it Vulvar Intraepithelial Neoplasia (VIN)? ☐ Yes ☐ No

k. Is the condition a bone marrow malignancy which does not require recurrent blood transfusions, chemotherapy, targeted cancer therapies, bone marrow transplant, haematopoietic stem cell transplant or other major interventionist treatment? ☐ Yes ☐ No

15. Please complete if the condition is Skin Cancer:

a. Is it a non-melanoma skin carcinoma? ☐ Yes ☐ No

b. Is it non-invasive melanoma histologically described as “in-situ”? ☐ Yes ☐ No

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c. Is it malignant melanoma that has not invaded beyond the epidermis? ☐ Yes ☐ No

d. Is it hyperkeratosis skin cancer? ☐ Yes ☐ No

e. Is it basal cell skin cancer? ☐ Yes ☐ No

f. Is it squamous cell skin cancer? ☐ Yes ☐ No

g. Is it skin confined primary cutaneous lymphoma or dermatofibrosarcoma proturberans? ☐ Yes ☐ No

h. Is it invasive melanoma of less than 1.5mm Breslow thickness, or less than Clark Level 3? ☐ Yes ☐ No

If Yes, please provide details of size, thickness and depth of invasion.
Please also state if there any pathologic evidence of invasion beyond the epidermis or metastases to lymph nodes.

_____

_____

16. Please complete if the condition is Prostate Cancer:

a. Is it Prostatic Intraepithelial Neoplasia (PIN)? ☐ Yes ☐ No

b. Is it histologically described as T1NoMo or below? ☐ Yes ☐ No

If Yes, please circle the exact stage of T1 classification. T1a / T1b / T1c

17. Please complete if the condition is Thyroid Cancer:

a. Is it histologically described as T1NoMo or below? ☐ Yes ☐ No

If Yes, please state the size in diameter.

_____

b. Is it Papillary micro-carcinoma of thyroid less than 1 cm in diameter? ☐ Yes ☐ No

18. Please complete if condition is Urinary Bladder Cancer:

a. Is it histologically described as Tis? ☐ Yes ☐ No

b. Is it histologically described as T1NoMo or below? ☐ Yes ☐ No

c. Is it Papillary micro-carcinoma? ☐ Yes ☐ No

d. Is it non-invasive papillary urothelial carcinoma of the bladder stage Ta? ☐ Yes ☐ No

19. Please complete if the condition is Gastro-Intestinal Stromal tumours (GIST):

a. Is it histologically described as T1NoMo or below with mitotic count of less than or equal to 55/50 HPFs? ☐ Yes ☐ No

b. Is it histologically classified as Stage 1 or 1A according to latest edition of the AJCC Cancer Staging Manual? ☐ Yes ☐ No

If No to above, please state the tumour TNM classification, its mitotic count in HPFs and AJCC staging.

_____

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20. Please complete if the condition is Chronic Lymphocytic Leukaemia (CLL):

    a. Is it RAI Stage 0 or lower? ☐ Yes ☐ No

    b. Is it less than RAI Stage 3? ☐ Yes ☐ No

    If No, please state the type of leukaemia and its RAI staging.

    _____

21. Please complete if the condition is Neuroendocrine tumour:

    a. Is it histologically classified as T1NoMo or below? ☐ Yes ☐ No

    If No, please state the type of tumour and its staging.

    _____

    b. Is it a pituitary neuroendocrine tumour (PitNET)? ☐ Yes ☐ No

    c. Is it metastatic PitNET or Pituitary Carcinoma? ☐ Yes ☐ No

22. Please provide details of treatment administered:

Treatment	From date (dd/mm/yyyy)	To date (dd/mm/yyyy)

23. Did the patient undergo any surgery? ☐ Yes ☐ No

    If Yes, please provide details and copy of operation report.

Date of surgery (dd/mm/yyyy)	Name / Nature of surgery	Organ removed	Total or Partial organ removal?

If surgery is planned, please indicate the nature of surgery and the planned date.

_____

24. If mastectomy was performed due to carcinoma in situ or cancer of breast, please state if reconstructive surgery was done? ☐ Yes ☐ No

    If Yes, please state the date of breast reconstructive surgery: _____(dd/mm/yyyy)

    If No and patient was recommended for reconstructive surgery, please state date of planned surgery: _____(dd/mm/yyyy)

    Was there surgical removal of at least three quadrants of the tissue of a breast? ☐ Yes ☐ No

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25. Does patient require a major organ or bone marrow transplant? ☐ Yes ☐ No
If Yes, please provide details:

Which organ is involved?	Reason for transplant	Date of transplant (dd/mm/yyyy)	Prognosis

For bone marrow transplant, is the receipt of transplant from human bone marrow using haematopoietic stem cells preceded by total bone marrow ablation? ☐ Yes ☐ No

26. Has the patient's condition resulted in him/her to be physically or mentally disabled from ever continuing in any employment? ☐ Yes ☐ No

If Yes, please provide details on patient's main physical and mental impairment/limitation:

_____

_____

_____

What is your reason that patient is incapable of any employment throughout his/her lifetime?

_____

_____

27. In your opinion, is patient's condition highly likely to lead to death within next 12 months? ☐ Yes ☐ No

If Yes, please provide your reason of your evaluation:

_____

_____

28. 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. 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 biopsy & histopathological results, imaging studies and scans etc.
- All relevant hospital / surgical reports, 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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