DOCTOR'S STATEMENT
(Open-Heart Heart Valve Surgery / Valve Replacement or Repair / Percutaneous Valvuloplasty)

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 (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. Please provide details of the heart disease leading to heart valve surgery.

_____

_____

5. When was the date of onset of heart valve abnormality? _____(dd/mm/yyyy)

6. What was the exact diagnosis?

_____

_____

7. When was the diagnosis first made known to the patient? _____(dd/mm/yyyy)

8. 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

9. 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

10. Was the diagnosis supported by cardiac catheterisation, echocardiogram or other reliable imaging technique? ☐ Yes ☐ No

If Yes, please provide details and attach copy of the result.

Imaging techniques (Echocardiogram, Catheterisation etc)	Date of imaging techniques	Findings

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If No, please provide clinical basis for the diagnosis of heart valve abnormality as established by cardiologist.

_____

_____

11. Has the patient undergone any procedure or surgery for treatment of the heart valve abnormality? ☐ Yes ☐ No

    If Yes, please provide details:

    a. Date patient first become aware that heart valve procedure was necessary? _____(dd/mm/yyyy)

    b. Date of procedure? _____(dd/mm/yyyy)

    c. What procedure was performed?
    (i.e. open heart surgery, percutaneous intravascular balloon valvuloplasty, partial sternotomy, mini-thoracotomy etc)

    _____

    _____

    d. Did the patient undergone:

        i. Open- Heart surgery with incision on the heart for the direct visual replacement or repair of heart valve abnormalities? ☐ Yes ☐ No

        ii. Heart valve replacement where clips and rings are deployed by the arterial route or repair by percutaneous transvascular or other minimally invasive intra-thoracic cardiac surgery? ☐ Yes ☐ No

        iii. Simple percutaneous transvascular balloon valvuloplasty or valvotomy without deployment of device or prosthesis? ☐ Yes ☐ No

        iv. Operation or procedure performed via endoscopic or keyhole surgery only? ☐ Yes ☐ No

        v. Operation or procedure performed via catheterization only? ☐ Yes ☐ No

    e. Was there deployment of a device or prothesis? ☐ Yes ☐ No
    If Yes, please provide details including date of procedure:

    _____

    _____

    _____

    f. Please provide details of the surgeon who performed the surgery:

Name of surgeon	Name & Address of the hospital where the surgery was done

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g. Was the surgery considered medically necessary by the cardiologist? ☐ Yes ☐ No
If Yes, please provide your basis:

_____

_____

If No, please provide details of treatment or management:

_____

_____

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

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.

_____

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E. Medical reports

Please attach copies of the following reports:

- All diagnostic investigation including Echocardiogram, Cardiac catheterization, Operation reports etc.
- All relevant hospital/surgical, laboratory and test results etc.

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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