

CRISIS COVER CLAIM FORM

OTHER CRITICAL ILLNESS & MEDICAL CONDITION

Important Notes

1. Please note that, under the policy terms and condition, the policy may be void if any information provided in this claim form are made knowingly by you that it is materially false or misleading.
2. The issue of this form is in no way an admission of liability. No claim can be considered unless the medical specialist report section is furnished at the expense of the claimant.
3. The Company reserves the rights to request for additional documents when deemed necessary.
4. This form is required to be completed by the life assured and/ or the policy owner. Where it is necessary for the Next of Kin ("NOK") to sign on behalf of the life assured and/ or the policy owner, PACS will require additional information on the reason for this request and supporting documents to be submitted to our satisfaction to accept this request. If the life assured/ policy owner is deemed mentally incapacitated and/or there is any medical evidence and/or evidence of mental incapacitation, PACS will and/or may also require a court order or a Lasting Power of Attorney ("LPA") to be submitted for our assessment.

PART I

(To be completed by the Life Assured who is at least 18 years old or the Policyowner if the Life Assured is below 18 years old)

DETAILS OF POLICY

Policy Number(s) the benefit(s) you would like to claim:

DETAILS OF LIFE ASSURED

Full Name					
NRIC / Passport No.		Date of birth		Gender	
Address					
Contact No.			Email address		
Occupation			Name and address of Employer		

TYPE OF CLAIM

1. Please tick [✓] in the appropriate box for the respective category of benefit and to state the type of illness / medical conditions you are claiming on the above policy(ies).

☐ Critical Illness	☐ Early / Intermediate/ Pre-critical Medical Conditions
--	---

DETAILS OF ILLNESS / MEDICAL CONDITION

2. Describe fully the signs or symptoms for which Life Assured has consulted doctor or received treatment.

3. Date when signs or symptoms first started		DD		MM		YYYY
4. Date when Life Assured first consulted a doctor for the above signs or symptoms.		DD		MM		YYYY
5. Please provide the following details accordingly if the consultation was due to illness or accident.						
If consultation was for illness, describe fully the nature and extent of illness in terms of its diagnosis and treatment received.	If consultation was due to accident, describe fully the date of accident, how and where did the accident occur.					
	Was the accident reported to the police?				Yes	No
	If yes, please provide: - the name of police officer and police station at which the accident was reported; and - a copy of the police report.					
6. Has Life Assured previously suffered from or received treatment for a similar or related illness / injury?					Yes	No
If yes, please give details.						
7. Please provide the details of all doctors or specialists whom Life Assured has consulted in connection with his/her illness/injury:-						
Name of Doctor	Name and Address of Clinic / Hospital	Dates of consultation	Reason(s) for consultation			

8. Please provide the details of Life Assured's regular doctor and company doctor whom he/she has consulted for minor ailments (e.g. flu, cough, fever), high blood pressure, high cholesterol, diabetes etc.:-

Name of Doctor	Name and Address of Clinic / Hospital	Dates of consultation	Reason(s) for consultation

OTHER INSURANCE

9. Does Life Assured have similar benefits with any other company? If yes, please give full details :-

Name of Insurer	Type of Plan	Date of Issue	Sum Assured

PAYMENT METHOD FOR CLAIM SETTLEMENT

Note:

- All claim payments in Singapore Dollars (SGD) will be made via **PayNow (NRIC/FIN)** or **Direct Credit** only.
- If no option is selected, payment will be made via **PayNow (NRIC/FIN)** by default.
- For policies with **joint owners, joint trustees, or joint assignees, Direct Credit with joint bank account details is required.**
- For **overseas payments** or payments in **foreign currencies**, please select **Telegraphic Fund Transfer**.

☐ PayNow NRIC/FIN (Default Payment Method)

- To ensure a smooth and timely payout, the PayNow account registered for this payment must be **linked to the NRIC/FIN**.
- Please submit a **copy of the Account Holder's NRIC or identity document**, showing the name and NRIC/FIN number.

To register for PayNow

- Log in to your bank's internet or mobile banking account
- Sign up for PayNow
- Link your PayNow to your NRIC/FIN

☐ Direct Credit

Account Holder's Name	Name of Bank	Bank Account Number

- Please submit a copy of the **bank book or bank statement**, stating the **Account Holder's Name and bank account number**. We accept bank statements with balances and transactions blacked out, as well as truncated e-statements downloaded from the bank's mobile application, provided that the document shows the **Account Holder's Name and bank account number on the same page**.
- If the copy of the bank book or bank statement is not submitted, or the details cannot be verified, payment will be made via **PayNow (NRIC/FIN)** by default.

☐ **Telegraphic Fund Transfer**

Account Holder's Name	Bank Account Number	Swift Code
Currency Requested	Name of Bank	Bank Address **
Additional Information (If Applicable)***		

**Bank Address needs to include all relevant information e.g. Unit/Floor no., Building/Street Name, State Code & Country.

***Please provide a relevant code/number under the Additional Information column if currency is listed below.

- Please submit a copy of the **bank book or bank statement**, stating the **Account Holder's Name and bank account number**. We accept bank statements with balances and transactions blacked out, as well as truncated e-statements downloaded from the bank's mobile application, provided that the document shows the **Account Holder's Name and bank account number on the same page**.
- Charges incurred for **Telegraphic Fund Transfer requests** will be deducted from the payment amount.

Currency	Additional Information (Code/Number)
Australia Dollar (AUD)	BSB Code
Euro Dollar (EUR)	IBAN Code
Pound Sterling (GBP)	IBAN & Sorting Code
US Dollar (USD)	ABA Routing Number
India Rupee (INR)	IFSC Code

Name of Life Assured:

NRIC / Passport No. of Life Assured:

DECLARATION

1. I understand and agree that the submission of this form does not mean that my request will be processed. I understand that any payout under the policy shall be strictly in accordance with the policy terms and conditions.
2. I hereby declare that the information that is disclosed on this form is to the best of my knowledge and belief, true, complete and accurate, and that no material information has been withheld or is any relevant circumstances omitted. I further acknowledge and accept that Prudential Assurance Company Singapore (Pte) Limited ("**PACS**") shall be at liberty to deny liability or recover amounts paid, whether wholly or partially, if any of the information disclosed on this form is incomplete, untrue or incorrect in any respect or if the Policy does not provide cover on which such claim is made.
3. I hereby warrant and represent that I have been properly authorised by the policyholder and the applicable insured(s) to submit information pertaining to such insured's claims.
4. I acknowledge and accept that the furnishing of this form, or any other forms supplemental thereto, by PACS, is neither an admission that there was any insurance in force on the life in question, nor an admission of liability nor a waiver of any of its rights and defenses.
5. I acknowledge and accept that PACS expressly reserves its rights to require or obtain further information and documentation as it deems necessary.
6. I confirm that I have paid in full all the bill(s)/invoice(s)/receipt(s) that I have submitted to PACS for reimbursement and have not claimed and do not intend to claim from other company(ies)/person(s).
7. I agree to produce all original bill(s)/invoice(s)/receipt(s) that were submitted for reimbursement to PACS for verification as it deems necessary.
8. For the purposes of (i) assessing, processing and/or investigating my claim(s) arising under the Policy or any of my other polic(ies) of insurance with PACS and such other purposes ancillary or related to the assessing, processing and/or investigating of such claim(s); (ii) administering the Policy, (iii) customer servicing, statistical analysis, conducting customer due diligence, reporting to regulatory or supervisory authorities, auditing and recovery of any debts owing to PACS whether in relation to the Policy or any of my other polic(ies) of insurance with PACS, (iv) storage and retention, (v) meeting requirements of prevailing internal policies of PACS, and/or (vi) as set out in PACS Privacy Notice ("**Purpose**"), I authorise, agree and consent to:
 - a. Any person(s) or organisation(s) that has relevant information concerning the policyowner and the insured person(s) (including any medical practitioner, medical/healthcare provider, financial service providers, insurance offices, government authorities/regulators, statutory boards, employer, or investigative agencies) ("**Person(s)/Organisation(s)**"), to disclose, release, transfer and exchange any information with PACS and its related corporations, respective representatives, agents, third party service providers, contractors and/or appointed distribution/business partners (collectively referred to as "**Prudential**"), including without limitation, personal data, medical information, medical history, employment and financial information, including the taking of copies of such records; and
 - b. Prudential collecting, using, disclosing, releasing, transferring and exchanging personal data about me, the policyowner and the insured person(s), with the Person(s)/Organisation(s), PACS's related group of companies, third party service providers, insurers, reinsurers, suppliers, intermediaries, lawyers/law firms, other financial institutions, law enforcement authorities, dispute resolution centres, debt collection agencies, loss adjustors or other third parties for the Purpose.
9. Where any personal data ("**3rd Party Personal Data**") relating to another person ("**Individual**") (including without limitation, insured persons, family members, and beneficiaries) is disclosed by me or permitted by me to be disclosed in accordance with Clause 8 above, I represent and warrant that I have obtained the consent of the Individual for Prudential to collect and use the 3rd Party Personal Data and to disclose the 3rd Party Personal Data to the persons enumerated above, whether in Singapore or elsewhere, for the Purpose stated above and in PACS Privacy Notice.
10. I understand that I can refer to PACS Privacy Notice, which is available at <https://www.prudential.com.sg/Privacy-Notice> for more information on contacting PACS for Feedback, Access, Correction and Withdrawal of using my/our personal data. I understand that if I am an European Union ("EU") resident individual (i.e. my residential address is based in any of the EU countries), I can refer to PACS Privacy Notice for more information on the rights available to me under the GDPR.
11. I agree to indemnify Prudential for all losses and damages that Prudential may suffer in the event that I am in breach of any representation and warranty provided to me herein.
12. I agree to receive communication on the claim by email, SMS and/or hard copies by post.
13. I agree that this (i) Prudential shall have full access to the information stated in this form, and (ii) this authorisation and declaration shall form part of my proposed application for the relevant insurance benefits, and a photocopy of this form shall be treated as valid and binding as if it were the original.

Date and signature of Life Assured
(Policyowner to sign if Life Assured is below age 18 years)

Date and signature of Policyowner

Name of Patient:

NRIC / Passport No. of Patient:

PART II - MEDICAL SPECIALIST REPORT
CRITICAL ILLNESS, EARLY & INTERMEDIATE STAGE MEDICAL CONDITIONS
(To be completed by the Life Assured's attending medical specialist)

Please circle the appropriate illness/disease/condition in the table and complete the relevant sections in respect to the illness/disease/condition claims. **Please submit ONLY the relevant sections to us upon completion.**

S/N	Critical Illness	Early / Intermediate / Pre-critical medical conditions		Sections to be completed
1	Alzheimer's Disease / Severe Dementia	Moderately Severe Alzheimer's Disease or Dementia	-	1, 2, 41
2	Persistent Vegetative State (Apallic Syndrome)	Akinetic Mutism	Locked in syndrome	1, 3, 41
3	Irreversible Aplastic Anaemia	Reversible Aplastic Anaemia	Myelodysplastic Syndrome or Myelofibrosis	1, 4, 41
4	Severe Bacterial Meningitis	Bacterial Meningitis with full recovery	Bacterial meningitis with reversible neurological deficit	1, 5, 41
5	Blindness (Irreversible Loss of Sight)	Loss of sight in one eye	Optic Nerve Atrophy with low vision	1, 6, 41
6	Coma	Coma for 48 hours	Severe Epilepsy or Coma for 72 hours	1, 7, 41
7	Deafness (Irreversible Loss of Hearing)	Partial loss of hearing or Cavernous sinus thrombosis surgery	Cochlear implant surgery	1, 8, 41
8	End Stage Liver Failure	Liver surgery	Liver Cirrhosis	1, 9, 41
9	End Stage Lung Disease	Severe Asthma or Insertion of a Veno-cava filter	Surgical removal of one lung	1, 10, 41
10	Fulminant Hepatitis	Hepatitis with Cirrhosis or Biliary Tract reconstruction surgery	Chronic Primary Sclerosing Cholangitis	1, 11, 41
11	Open-Heart Heart Valve Surgery	Percutaneous Valvuloplasty or Valvotomy	Percutaneous valve replacement or device repair	1, 12, 41
12	HIV Due to Blood Transfusion and Occupationally Acquired HIV	HIV due to Assault or Occupationally Acquired HIV	HIV due to Organ Transplant	1, 13, 41
13	Loss of Independent Existence	Loss of independent existence (early stage)	Loss of independent existence (intermediate stage)	1, 14, 41
14	Irreversible Loss of Speech	Loss of Speech due to neurological disease or neurological injury or Permanent or Temporary Tracheostomy	Bilateral Vocal cord paralysis	1, 15, 41
15	Major Burns	Mild severe burns	Moderately severe burns	1, 16, 41
16	Major Head Trauma	Facial reconstructive surgery or Spinal cord injury	Head Trauma Requiring Open Craniotomy / Surgery for subdural haematoma	1, 17, 41
17	Major Organ / Bone Marrow Transplantation	Small bowel transplant or Corneal transplant	Major organ/ bone marrow transplant (on waitlist)	1, 18, 41
18	Motor Neurone Disease	Early Motor Neurone Disease or Severe Peripheral Neuropathy	-	1, 19, 41
19	Multiple Sclerosis	Early Multiple Sclerosis	Mild Multiple Sclerosis	1, 20, 41
20	Muscular Dystrophy	Moderately severe Muscular Dystrophy or Spinal Cord Disease or Injury resulting in Bowel and Bladder Dysfunction	-	1, 21, 41
21	Paralysis (Irreversible Loss of Use of Limbs)	Loss of Use of One Limb	Loss of Use of One Limb requiring Prosthesis	1, 22, 41
22	Idiopathic Parkinson's Disease	Early and moderately severe Parkinson's Disease	-	1, 23, 41
23	Poliomyelitis	Severe Peripheral neuropathy	Moderately Severe Poliomyelitis	1, 24, 41

S/N	Critical Illness	Early / Intermediate / Pre-critical medical conditions		Sections to be completed
24	Primary Pulmonary Hypertension / Pulmonary Arterial Hypertension	Early Pulmonary Hypertension	Secondary Pulmonary Hypertension	1, 25, 41
25	Progressive Scleroderma	Early Progressive Scleroderma	Progressive Scleroderma with CREST syndrome	1, 26, 41
26	Surgery to Aorta	Minimally invasive surgery to Aorta or Large asymptomatic aortic aneurysm	-	1, 27, 41
27	Systemic lupus erythematosus with lupus nephritis	Mild systemic lupus erythematosus	Moderately severe systemic lupus erythematosus with lupus nephritis	1, 28, 41
28	Severe Encephalitis	Viral Encephalitis with full recovery	Moderate Viral Encephalitis with full recovery	1, 29, 41
29	Open Surgery of Major Organs	-	-	1, 30, 41
30	ICU Admission	-	-	1, 31, 41
31	Biliary atresia having undergone liver transplantation	Biliary Atresia (on diagnosis)	-	1, 32, 41
32	Creutzfeld-Jakob disease	Less Severe Creutzfeldt-Jakob Disease	Moderately Severe Creutzfeldt-Jakob Disease	1, 33, 41
33	Meningeal tuberculosis	Tuberculous Myelitis	-	1, 34, 41
34	Necrotising fasciitis	Early Stage Necrotising Fasciitis	-	1, 35, 41
35	Progressive Supranuclear Palsy	Less Severe Progressive Supranuclear Palsy	-	1, 36, 41
36	Severe Eisenmenger's Syndrome	Less Severe Eisenmenger's Syndrome	-	1, 37, 41
37	-	Maffucci Syndrome	-	1, 38, 41
38	-	Ollier's Disease	-	1, 39, 41
39	-	Guillain-Barre Syndrome - of specified severity	-	1, 40, 41

Name of Patient:

NRIC / Passport No. of Patient:

SECTION 1 : GENERAL INFORMATION

1. Date when patient first consulted you for the condition?		DD		MM		YYYY	
2. When was the last consultation?		DD		MM		YYYY	
3. What were the presenting symptoms when you first saw the patient?							
4. When did the above symptoms first present?		DD		MM		YYYY	
5. Please provide exact diagnosis:							
6. What is/are the underlying cause(s)?							
7. Date of diagnosis.		DD		MM		YYYY	
8. Date when patient / patient's next of kin first informed of the diagnosis.		DD		MM		YYYY	
9. Please provide dates and details of investigation performed for the diagnosis. Kindly attach copies of all relevant objective test reports, which confirmed the diagnosis.							
10. Were you the doctor who first diagnosed the patient with this condition?						Yes	No
11. If Yes, over what period do your records extend?				From (DD/MM/YYYY)	To (DD/MM/YYYY)		
12. If you are not the first doctor who diagnosed the patient with this condition, please provide:							
a. Name and practice address of the doctor who first made the diagnosis or had treated the patient for this condition:							
b. Date the diagnosis was made by the previous doctor.		DD		MM		YYYY	
c. When was the referral made for the patient to see you?		DD		MM		YYYY	
d. What was the reason for referral to see you? Please attach a copy of the referral letter.							

SECTION 2 : ALZHEIMER'S DISEASE / SEVERE DEMENTIA / MODERATELY SEVERE ALZHEIMER'S DISEASE OR DEMENTIA

1. Is there evidence of deterioration or loss of intellectual capacity or cognitive function?	Yes	No
2. Is there abnormal behavior resulting in significant reduction in mental and social functioning requiring the continuous supervision of patient?	Yes	No
3. If Yes to Q1 and/or Q2, please describe the extent of the disease and patient's behavior.		

Signature & Practice Stamp of the Medical Specialist who filled up Part II

Date

Name of Patient:

NRIC / Passport No. of Patient:

4. Does the patient require continuous supervision as a result of the significant reduction in mental and social functioning described in Q2 & Q3?	Yes	No
If Yes, please provide the basis of your evaluation and state the date on which such continuous supervision was first required.		
5. Please describe the progression of the patient's Alzheimer's disease/dementia condition since the time he/she was first and last seen at the Hospital/clinic.		
6. Please circle your reply if the patient's deterioration or loss of intellectual capacity or abnormal behavior arises from any of the following?		
a. Non-organic disease such as neurosis and psychiatric illness?	Yes	No
b. Head injury related brain damage?	Yes	No
c. Alcohol related brain damage?	Yes	No
d. Drug related brain damage?	Yes	No
e. Any other disease/infections?	Yes	No
7. Was there permanent clinical loss of the ability to do any of the following:		
a. Remember	Yes	No
b. Reason	Yes	No
c. Perceive, understand, express and give effect to ideas	Yes	No
8. Please provide full details and results of all investigation (with dates) performed for the diagnosis. Please also attach a copy of all relevant test reports (e.g. Mini-Mental State Examination (MMSE) or other equivalent Alzheimer's tests) which confirmed the diagnosis.		
Type of test/assessment	Date of test/assessment	Results of test/assessment
SECTION 3 : PERSISTENT VEGETATIVE STAGE (APALLIC SYNDROME)/ AKINETIC MUTISM/ LOCKED IN SYNDROME		
1. Is there presence of universal necrosis of the brain cortex with the brainstem intact?	Yes	No
If Yes, please provide full details, including the neurological deficit.		
2. Is there organic brain damage which resulted in the patient's inability to talk or move despite being alert at times?	Yes	No
If yes, please provide details of organic brain damage suffered with supporting medical evidence.		
3. Is there inability to move or communicate verbally due to complete paralysis of all voluntary muscles in the body despite being aware?	Yes	No

Signature & Practice Stamp of the Medical Specialist who filled up Part II	Date
--	------

Name of Patient:

NRIC / Passport No. of Patient:

4. Is there vertical eye movements and blinking?	Yes	No
5. Was the diagnosis supported by evidence showing organic brain damage according to Cairns et al. criteria and confirmed by a consultant neurologist?	Yes	No
6. Is there evidence of the following:		
1. Quadriplegia and inability to speak	Yes	No
2. Infarction of the ventral pons	Yes	No
3. EEG indicating that the patient is not unconscious	Yes	No
7. Did the condition persist for at least one month since its onset?	Yes	No
If Yes, please state the duration for which it persisted and to support with a copy of the medical documentation.		
8. Is the patient's condition expected to improve?	Yes	No
If Yes, please advise the extent of recovery and the duration to expect for such recovery to take place.	If No, please explain with supporting medical evidence.	
9. Is the patient's condition due to psychological reasons?	Yes	No
If Yes, please provide details.		
10. Is the patient's condition in a way related or due to AIDS or HIV related illness?	Yes	No
If Yes, please provide details.		
SECTION 4 : IRREVERSIBLE APLASTIC ANAEMIA / REVERSIBLE APLASTIC ANAEMIA / MYELODYSPLASTIC SYNDROME OR MYELOFIBROSIS		
1. Please provide full details of tests and results which have been performed to establish the diagnosis of Aplastic Anaemia.		
2. What is the cause of patient's aplastic anaemia?		
a. Acute reversible bone marrow failure?	Yes	No
b. Chronic persistent and irreversible bone marrow failure?	Yes	No
3. Was any of the following present? If Yes, please provide us with the relevant laboratory results.		
a. Anaemia?	Yes	No
b. Neutropenia?	Yes	No
c. Thrombocytopenia	Yes	No
Signature & Practice Stamp of the Medical Specialist who filled up Part II		Date

Name of Patient:

NRIC / Passport No. of Patient:

4. Does the patient require or has received any of the following treatment?		
a. Blood product transfusions?	Yes	No
b. Bone marrow stimulating agents?	Yes	No
c. Immunosuppressive agents?	Yes	No
d. ☐ Bone marrow transplantation; or ☐ Hematopoietic stem cell transplantation?	Yes	No
e. Chemotherapy?	Yes	No
5. Please provide details of treatment administered, including date/period of treatment, name and address of attending doctors.		
6. Was the patient's condition diagnosis of Myelodysplastic Syndrome (MDS) or Myelofibrosis confirmed on marrow biopsy?	Yes	No
7. Is the patient's condition in any way attributable to Human Immunodeficiency virus (HIV) infection or Acquired Immune Deficiency Syndrome (AIDS)?	Yes	No
If Yes to Q6 & Q7, please provide more details to your answer.		
SECTION 5 : SEVERE BACTERIAL MENINGITIS / BACTERIAL MENINGITIS WITH FULL RECOVERY		
1. Is there severe inflammation of the membranes of the brain or spinal cord?	Yes	No
2. Please describe what are the patient's present limitations, physical and mental?		
3. Have the neurological deficits (described in Q2 above) last for a continuous period of at least 6 weeks?	Yes	No
4. Are these neurological deficits irreversible and permanent?	Yes	No
a. If Yes, please provide details of the deficits and elaborate with supporting evidence.	b. If No, please state date of recovery or date for which patient is likely to recover from these neurological deficits? (DD/MM/YYYY)	
5. Was the condition present due to HIV / AIDS infections?	Yes	No
If Yes, please provide details including date of diagnosis, name and address of the doctor who first made the diagnosis.		
SECTION 6 : BLINDNESS (IRREVERSIBLE LOSS OF SIGHT) / LOSS OF SIGHT IN ONE EYE / OPTIC NERVE ATROPHY WITH LOW VISION		
1. What is the patient's current visual acuity of both eyes using Snellen eye chart?		
Visual acuity on left eye :		Visual acuity on right eye :
Date of assessment:	(DD/MM/YYYY)	Date of assessment: (DD/MM/YYYY)
Signature & Practice Stamp of the Medical Specialist who filled up Part II		Date

Name of Patient:

NRIC / Passport No. of Patient:

2. What is the patient's current visual field in both eyes? Visual field on left eye: Visual field on right eye: Date of assessment: (DD/MM/YYYY) Date of assessment: (DD/MM/YYYY)			
3. Is the visual loss permanent and irreversible in one or both eyes?		Yes	No
If Yes, please indicate which eye is affected and to support your basis with the relevant medical reports.			
4. Will any surgical procedures, implants or other means of treatment improve or could reinstate patient's vision on either or both eyes? If Yes, please provide details.		Yes	No
a. Please state name and type of surgical procedure, implant or means of treatment.			
b. Has such treatment been recommended to patient?		Yes	No
If No, why is the reason?	If Yes, when is the scheduled date of surgery/ implant or commencement date of treatment? (DD/MM/YYYY)		
c. Using the Snellen eye chart, what is the best corrected visual acuity of both eyes?	Left eye	Right eye	
5. Has the patient suffered from Optic Nerve Atrophy with low vision? If Yes, please advise the following:		Yes	No
a. How was the diagnosis of optic nerve atrophy established?			
b. Are both eyes affected as a result of optic nerve atrophy? Please circle.		Yes	No
If Yes, please provide details.			
c. Using the Snellen eye chart, what is the best corrected visual acuity of both eyes?	Left eye	Right eye	
6. Is the patient's condition resulting from alcohol or drug misuse?		Yes	No
If Yes, please provide us with the details.			
SECTION 7 : COMA / COMA FOR 48 HOURS / SEVERE EPILEPSY OR COMA FOR 72 HOURS			
1. How was the diagnosis of Coma established? Please attach a copy of the diagnostic investigation reports (e.g. electroencephalography (EEG), Magnetic Resonance Imaging (MRI), Position Emission Tomography (PET) etc.).			
Signature & Practice Stamp of the Medical Specialist who filled up Part II		Date	

Name of Patient:

NRIC / Passport No. of Patient:

2. Was there any reaction or response to external stimuli or internal needs persisting continuously with the use of a life support system for:		
a. At least 48 hours?	Yes	No
b. At least 72 hours?	Yes	No
c. At least 96 hours?	Yes	No
If Yes to any of the above, please support the basis with medical evidence.	If No to all of the above, please state how many hours was the patient in a state of coma, with no response to external stimuli?	
3. Was the patient put on life support measures?		No
If Yes, please advise the date patient was put on life support measures and details of such life support measures.		
4. Had the patient woke up from the state of coma, with no response to external stimuli?		No
If Yes, please state the date and time patient has woke up from the state of coma.		
5. Was there any brain damage resulting in permanent neurological deficit?		No
a. Has the neurological deficit lasted for more than 30 days from the onset of coma?	Yes	No
b. Please provide date(s) of assessment and describe the neurological deficits presented during each visit.		
6. Is the patient diagnosed with Epilepsy? If Yes, please state the following:		No
a. How was the diagnosis of Epilepsy established?		
b. Has the patient experienced recurrent unprovoked tonic-clonic or grand mal seizures and be known to be resistant to optimal therapy as confirmed by drug serum level testing?		No
If Yes, please state date(s) of attack(s) and the frequency of attack(s).		
c. Is the patient taking prescribed anti-epileptic (anti-convulsant) medications?		No
If Yes, please state the type(s) of medication and how long has patient been on such medication.		

Signature & Practice Stamp of the Medical Specialist who filled up Part II	Date
--	------

Name of Patient:

NRIC / Passport No. of Patient:

7. Is patient's condition resulting from alcohol, drug misuse or medically induced coma?	Yes	No
If Yes, please provide us with the details.		
8. Is patient's condition resulting from self-inflicted injuries?	Yes	No
If Yes, please provide us with the details.		
SECTION 8 : DEAFNESS (IRREVERSIBLE LOSS OF HEARING) / PARTIAL LOSS OF HEARING OR CAVERNOUS SINUS THROMBOSIS SURGERY / COCHLEAR IMPLANT SURGERY		
1. Was the diagnosis confirmed by an audiometric and sound-threshold?	Yes	No
2. Is there total loss of hearing in both ears?	Yes	No
3. What is the patient's current hearing ability in both ears (in decibels)?		
Hearing frequency in left ear :		Hearing frequency in right ear :
Date of assessment: (DD/MM/YYYY)		Date of assessment: (DD/MM/YYYY)
4. Is there a total loss in all frequencies of hearing of:		
a. at least 60 decibels	Yes	No
b. at least 80 decibels	Yes	No
5. Is the loss of hearing irreversible in both ears?	Yes	No
6. Can the hearing be restored to 40 decibels or lower by medical treatment, hearing aid and/ or surgical procedures consistent with the current standard of the medical services?	Yes	No
If yes, how long does it take to restore the hearing to 40 decibels or lower? _____ (number of months)		
7. Has the patient undergone surgery for Cavernous Sinus Thrombosis? If Yes, please state the following:	Yes	No
a. Type of surgery performed	b. Date the surgery was performed (DD/MM/YYYY)	
8. Has the patient undergone surgical cochlear implant?	Yes	No
a. Was there permanent damage to the cochlea or auditory nerve?	Yes	No
b. Please state the actual date of surgery.		DD MM YYYY
9. Will any surgery improve or could reinstate patient's hearing on either or both ears? If Yes, please provide details.	Yes	No
a. Please state name and type of surgery?		

Signature & Practice Stamp of the Medical Specialist who filled up Part II	Date
--	------

Name of Patient:

NRIC / Passport No. of Patient:

b. Has such surgery been recommended to patient?						Yes	No
If No, what is the reason?			If Yes, when is the scheduled date of surgery?				
			(DD/MM/YYYY)				
c. What is the best corrected hearing frequency in both ears?				Left ear		Right ear	
SECTION 9 : END STAGE LIVER FAILURE / LIVER SURGERY / LIVER CIRRHOSIS							
1. Was there end stage liver failure?						Yes	No
2. Please state the date where end stage liver failure was first diagnosed.				DD		MM	YYYY
3. Was there evidence of permanent jaundice?						Yes	No
4. How long has the patient been affected by jaundice?						months	
5. Was there evidence of ascites?						Yes	No
6. Please state the date where ascites was first discovered.				DD		MM	YYYY
7. Was there confirmation of ascites by paracentesis and/or by ultrasound?						Yes	No
If Yes, please provide details of the diagnostic findings and to attach a copy of the results.							
8. Was there evidence of hepatic encephalopathy?						Yes	No
If Yes, please provide details including dates, underlying causes, complications (if any) and treatment.							
9. Was there partial hepatectomy of at least one entire lobe of the liver? If Yes, please state the following:						Yes	No
a. Date the surgery was performed			b. Reason for requiring partial hepatectomy. Please support with evidence why surgery is absolutely necessary.				
(DD/MM/YYYY)							
10. Was there cirrhosis of liver? Please circle.						Yes	No
If Yes, please provide us with the HAI-Knodell Scores together with the liver biopsy result.							
11. What was the cause of the liver failure?							
12. Was the liver disease suffered by the patient secondary to alcohol abuse?						Yes	No
Signature & Practice Stamp of the Medical Specialist who filled up Part II						Date	

Name of Patient:

NRIC / Passport No. of Patient:

13. Was the liver disease suffered by the patient secondary to drug abuse?					Yes	No
If Yes to Q12 & Q13, please give details of the patient's habits in relation to alcohol assumption, including the amount of alcohol consumption per day and source of this information.						
14. What is the current condition of the patient and his/her prognosis?						
SECTION 10 : END STAGE LUNG DISEASE / SEVERE ASTHMA OR INSERTION OF A VENO-CAVA FILTER / SURGICAL REMOVAL OF ONE LUNG						
1. Please describe the patient's lung disease.						
2. Has the patient's lung disease reached end-stage? Please circle.					Yes	No
3. Please state the exact date patient's lung disease has reached end-stage.		DD		MM		YYYY
4. Is the patient's FEV ₁ test results consistently less than 1 litre? Please circle.					Yes	No
If No, please state patient's FEV ₁ test result and to provide dates and details of all investigations carried out, including pulmonary function tests. To attach a copy of all the pulmonary function tests results.						
5. Does the patient require extensive and permanent oxygen therapy for hypoxemia?					Yes	No
a. Please advise the start date.		DD		MM		YYYY
b. Please state the frequency oxygen therapy is administered.						
6. Is the patient's arterial blood gas analysis with partial oxygen pressures of 55mmHg or less (PaO ₂ ≤ 55mmHg)?					Yes	No
a. If Yes, please provide full details of all arterial blood gas analysis results.		b. If No, please give the actual readings.				
7. Is there dyspnea at rest? Please circle.					Yes	No
8. Please provide dates and details of all investigations carried out, including pulmonary function test, current FEV ₁ and vital capacity readings.						
9. Is the patient suffering or has suffered from severe asthma condition? Please circle.					Yes	No
a. Was there evidence of an acute attack of severe asthma with persistent status of asthmaticus?					Yes	No
Signature & Practice Stamp of the Medical Specialist who filled up Part II					Date	

Name of Patient:

NRIC / Passport No. of Patient:

b. Was the patient hospitalized and required assisted ventilation with a mechanical ventilator?						Yes	No
i. Please advise date of admission.			DD		MM		YYYY
ii. Please advise date of discharge.			DD		MM		YYYY
iii. Is the patient on mechanical ventilator for a continuous period of at least 4 hours?						Yes	No
10. Is the patient suffering or has suffered from pulmonary emboli?						Yes	No
a. If Yes, please provide us with the first and subsequent dates, the presenting symptoms and diagnosis where the patient consulted you for each recurrence of pulmonary emboli.							
11. Has the patient undergone surgery to:						Yes	No
a. Insert vena-cava filter due to documented proof of recurrent pulmonary emboli?						Yes	No
b. Complete surgical removal of one lung as a result of an illness or an accident?						Yes	No
c. If Yes to Q11 (a) &/or (b), please state actual date of surgery.			DD		MM		YYYY
SECTION 11 : FULMINANT HEPATITIS / HEPATITIS WITH CIRRHOSIS OR BILIARY TRACT RECONSTRUCTION SURGERY / CHRONIC PRIMARY SCLEROSING CHOLANGITIS							
1. Please state the type of hepatitis virus diagnosed?							
2. What is the approximate date of commencement?			DD		MM		YYYY
3. Please provide the following information in relation to patient's diagnosis of fulminant hepatitis:							
a. Was a liver biopsy performed?						Yes	No
i. Please state date of biopsy?			DD		MM		YYYY
b. Was an abdominal ultrasound performed?						Yes	No
i. Please state date of ultrasound?			DD		MM		YYYY
c. Is there a submassive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure? If Yes, please advise:						Yes	No
i. Is there rapid decreasing of liver size?						Yes	No
If Yes, please advise the state of the liver and its lobular architecture.							
ii. Is there necrosis involving entire lobules, leaving only a collapsed reticular framework?						Yes	No
If Yes, please advise the extent of the liver necrosis and its lobular architecture.							
Signature & Practice Stamp of the Medical Specialist who filled up Part II						Date	

Name of Patient:

NRIC / Passport No. of Patient:

iii. Is there necrosis involving entire lobules, leaving only a collapsed reticular framework?					Yes	No
If Yes, please advise the extent of the liver necrosis and its lobular architecture.						
iv. Is there a rapid deterioration of liver function tests?					Yes	No
If Yes, please state the test results evident of the rapid deterioration and to attach a copy of the results.						
v. Is there deepening jaundice?					Yes	No
If Yes, please give full details.						
vi. Is there evidence of hepatic encephalopathy?					Yes	No
If Yes, please give full details, including dates, underlying causes, treatment and any complications.						
4. Is there a submassive necrosis of the liver by the hepatitis virus leading to cirrhosis?					Yes	No
a. Please provide the Metavir grading.			b. Please provide the Knodell fibrosis score			
5. Has the patient undergone biliary tract reconstruction surgery involving choledochoenterostomy (choledochojejunostomy or choledochoduodenostomy) for the treatment of biliary tract disease, including biliary atresia? If Yes, please advise the following:					Yes	No
i. If Yes, please advise when was the biliary tract reconstruction surgery done?				DD		MM
					YYYY	
ii. Is the biliary tract disease not amendable by other surgical or endoscopic measures?					Yes	No
iii. Is the procedure considered the most appropriate treatment?					Yes	No
iv. Is patient's current condition a consequence of gall stone disease or cholangitis?					Yes	No
6. Is patient's condition of chronic primary sclerosing cholangitis confirmed by cholangiogram? If Yes, please advise the following:					Yes	No
i. Is there progressive obliteration of the bile ducts?					Yes	No
ii. Is there permanent jaundice?					Yes	No
iii. Is the patient's biliary tract sclerosis or obstruction a consequence of biliary surgery, gall stone disease, infection, cancer, inflammatory bowel disease or other secondary precipitants?					Yes	No
If Yes, please provide details.						
Signature & Practice Stamp of the Medical Specialist who filled up Part II					Date	

Name of Patient:

NRIC / Passport No. of Patient:

7. Was the patient's condition caused directly or indirectly by alcohol or drug abuse?					Yes	No
If Yes, please give details.						
8. What is patient's current condition and the prognosis?						
SECTION 12 : OPEN-HEART HEART VALVE SURGERY / PERCUTANEOUS VALVULOPLASTY OR VALLVOTOMY / PERCUTANEOUS VALVE REPLACEMENT OR DEVICE REPAIR						
1. Please provide details of the heart disease leading to heart valve surgery.						
2. What is the date of onset of the heart valve abnormality?			DD		MM	YYYY
3. Please state the date where heart valve disease was diagnosed.			DD		MM	YYYY
4. Was the diagnosis supported by cardiac catheterization?					Yes	No
a. If Yes, please give details and attach a copy of cardiac catheterization results.			b. If No, please provide the justification based on to confirm the diagnosis of heart valve abnormality.			
5. Was the diagnosis supported by echocardiogram?					Yes	No
a. If Yes, please give details and attach a copy of echocardiogram report.			b. If No, please provide the justification based on to confirm the diagnosis of heart valve abnormality.			
6. Was surgery performed to repair or replace the heart valve abnormality? If Yes, please provide details:					Yes	No
a. What was the date when heart valve disease requiring surgery was first diagnosed?			DD		MM	YYYY
b. Please state the date patient first became aware that heart valve surgery was necessary.			DD		MM	YYYY
c. Please state date of the surgery.			DD		MM	YYYY
d. Was there any new valve or any percutaneous device or prosthesis deployed during surgical procedure (i.e. Percutaneous balloon valvuloplasty/ valvotomy and other percutaneous repair procedures etc.)					Yes	No
e. Was there replacement of heart valve by the deployment of a permanent device or prosthesis by percutaneous intravascular techniques not involving thoracotomy?					Yes	No
f. Please describe the surgical procedure used to correct the valvular problem (i.e. open heart surgery, percutaneous intravascular balloon valvuloplasty with OR without thoracotomy, valvotomy etc.)						
Signature & Practice Stamp of the Medical Specialist who filled up Part II					Date	

Name of Patient:

NRIC / Passport No. of Patient:

g. Was the surgery procedure stated in Q6(f) above a form of an open-heart surgery? (Open-heart surgery refers to an incision on the heart for the direct visual replacement or repair of the heart valve abnormalities)					Yes	No
If No, please state exact form of intervention.						
7. Was operation or procedure performed via endoscopic or keyhole surgery?					Yes	No
8. Was operation or procedure performed via catheterization?					Yes	No
SECTION 13 : HIV DUE TO BLOOD TRANSFUSION AND OCCUPATIONALLY ACQUIRED HIV / HIV DUE TO ASSAULT, OR OCCUPATIONALLY ACQUIRED HIV / HIV DUE TO ORGAN TRANSPLANT						
1. Was the infection due to:						
a. Blood transfusion					Yes	No
b. Organ transplant					Yes	No
c. Physical or sexual assault					Yes	No
2. Was the blood transfusion or organ transplant medically necessary or given as part of medical treatment?					Yes	No
a. Please state the date of blood transfusion or organ transplant.				DD		MM
3. Did the incident of infection occur in Singapore?					Yes	No
If Yes, please provide the exact date and details.						
4. Was the infection resulted from any other means including sexual activity and the use of intravenous drugs?					Yes	No
If Yes, please state the likely cause:						
5. Was the incident of infection established to involve a definite source of the HIV infected fluids?					Yes	No
6. Was the incident of infection reported to the appropriate authority?					Yes	No
7. Is the institution where the blood transfusion or organ transplant was performed able to trace the origin of the HIV tainted blood / HIV infected transplanted organ?					Yes	No
8. Is the patient suffering from Thalassaemia Major or Haemophilia?					Yes	No
9. Is the occupation of the patient a medical practitioner, houseman, medical student, state registered nurse, medical laboratory technician, dentist (surgeon and nurse) or paramedical worker, working in medical centre or clinic in Singapore?					Yes	No
If Yes, please state the actual occupation and name of employer or institution:						

Signature & Practice Stamp of the Medical Specialist who filled up Part II	Date
--	------

Name of Patient:

NRIC / Passport No. of Patient:

10. Was there an accident whilst the patient was carrying out the normal professional duties of his/her occupation in Singapore? If Yes, please advise the following:						Yes	No
a. Please state the date of accident.		DD		MM		YYYY	
b. Was the accident involved a definite source of the HIV infected fluids?						Yes	No
11. Was an HIV antibody test done after the incident of infection?						Yes	No
If Yes, what was the result?							
SECTION 14 : LOSS OF INDEPENDENT EXISTENCE							
1. Please elaborate in details the underlying cause of patient's condition?							
2. Please confirm if the patient's inability to perform any of the above activities of daily living is due to non-organic diseases such as neurosis or psychiatric illnesses						Yes	No
If Yes, please provide full details on the non-organic disease.							
3. Was the patient's condition a result of an accident? If Yes, please provide the following information:						Yes	No
a. What is date of accident?		DD		MM		YYYY	
b. Please describe where and how did the accident happened.							
c. Please describe the extent and severity of the bodily injuries/disability sustained, including exact site(s) of the body.							
4. If no, was it due to a self-inflicted injury?						Yes	No
5. Please describe and elaborate on the nature and severity of the patient's physical disability and limitation.							
6. Was there total and irreversible physical loss of all fingers including thumb of the same hand due to the above accident?						Yes	No
7. Please state date of last assessment in relation to patient's ability to perform activities of daily living?		DD		MM		YYYY	

Signature & Practice Stamp of the Medical Specialist who filled up Part II	Date
--	------

Name of Patient:

NRIC / Passport No. of Patient:

8. Based on the last date of assessment, please state your assessment if the patient is able to perform (whether aided* or unaided) the following Activities of Daily Living?

*Aided shall mean with the aid of special equipment, device and/or apparatus and not pertaining to human aid.

Activity	Please circle if the patient can perform the listed activity?		Period of inability to perform	
			From (DD/MM/YYYY)	To (DD/MM/YYYY)
Washing : Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.	Yes	No		
Dressing : Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical or medical appliances.	Yes	No		
Transferring : Ability to move from a bed to an upright chair or wheelchair and vice versa.	Yes	No		
Mobility : Ability to move indoors from room to room on level surfaces.	Yes	No		
Toileting : Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.	Yes	No		
Feeding : Ability to feed oneself food once food has been prepared and made available.	Yes	No		

9. What is the prognosis?

- If patient's condition is likely to improve, please state extent of improvement expected and estimated date of recovery.
- If the patient's condition is likely to deteriorate or remain static, please elaborate with reasons how you arrive at this opinion.

SECTION 15 : IRREVERSIBLE LOSS OF SPEECH / LOSS OF SPEECH DUE TO NEUROLOGICAL DISEASE OR NEUROLOGICAL INJURY OR PERMANENT OR TEMPORARY TRACHEOSTOMY / BILATERAL VOCAL CORD PARALYSIS

1. What is the date of onset patient loses the ability to speak?		DD		MM		YYYY
2. Has there been any improvement in the patient's speech since onset of the condition?	Yes					No
If No, please elaborate.						
a. Is the loss of speech as a result of injury to both vocal cords?	Yes					No
If Yes, please provide full and exact details, including date and the circumstance leading to the injury.						
b. Is the loss of speech as a result of disease to both vocal cords?	Yes					No
If Yes, please provide full and exact details, including dates of diagnosis and treatments.						
3. If No to Q3 & Q4, what was the cause of the loss of speech?						
Signature & Practice Stamp of the Medical Specialist who filled up Part II						Date

Name of Patient:

NRIC / Passport No. of Patient:

4. Is the loss of speech considered total and irrecoverable/ irreversible?					Yes	No
If Yes, please provide details of the investigation performed to confirm the loss is total and irrecoverable. Please attach a copy of the diagnostic test reports (e.g. fiberoptic nasolaryngoscopy, etc.)						
5. Will any surgery improve or could reinstate patient's ability to speak?					Yes	No
If Yes, please state what kind of surgery will be necessary and what is the tentative date of surgery?						
6. Did patient's inability to speak last for a continuous period of 12 months?					Yes	No
Please state the period of patient's inability to speak, including date of onset to last date of establishment.						
7. Were there any associated neurological or psychiatric conditions contributing to patient's loss of speech?					Yes	No
If Yes, please provide details on the date of diagnosis, exact diagnosis and contact details of attending doctor.						
8. Is the patient currently undergoing any speech therapy sessions?					Yes	No
a. If Yes, please state frequency and duration.			b. If No, please state the date of last speech therapy session.			
9. Has tracheostomy been performed?					Yes	No
a. When was tracheostomy done?		DD		MM		YYYY
b. What is the purpose of doing a tracheostomy?						
c. Was tracheostomy performed for treatment of lung or airway disease or a ventilator support measure following major trauma or burns?					Yes	No
If Yes, please give details on the purpose and the reason why it was required.						
d. Was the tracheostomy performed for the purpose of saving life?					Yes	No
If Yes, please provide more details to your answer.						
e. Was the tracheostomy tube in place and functional for a period of at least 3 months?					Yes	No
f. What is the date tracheostomy tube is removed?		DD		MM		YYYY
Signature & Practice Stamp of the Medical Specialist who filled up Part II					Date	

Name of Patient:

NRIC / Passport No. of Patient:

SECTION 16 : MAJOR BURNS / MODERATELY SEVERE BURNS

1. What is date of incident resulting in major burns?		DD		MM		YYYY	
2. Where and how did the incident happen resulting in the major burns?							
3. Is there reason to suspect that there were contributory circumstances which led to the burns injury, e.g. under the influence of alcohol, drugs, suicide or attempted suicide, etc.?						Yes	No
If Yes, please elaborate with details.							
4. Were the major burns a result of an accident? If Yes, please provide the following information:						Yes	No
a. What is date of incident resulting in major burns?		DD		MM		YYYY	
b. Where and how did the accident happen resulting in the major burns?							
c. Was there a police report made with regard to this accident? If Yes, please provide a copy.						Yes	No
5. Is the burns result from a self-inflicted act?						Yes	No
If Yes, please provide details.							
6. Please state the areas affected on the patient's body, the percentage of surface area, and the degree of burns in each affected area and to attach a copy of the burns report.							
Area affected	Percentage of surface area		Degree of burns				
a. Please confirm if the patient suffered from burns resulting in full thickness skin destruction of at least 10% of his/her body surface?						Yes	No
b. Please confirm if the patient suffered from Second Degree (partial thickness of the skin) burns covering at least 20% of the surface of his/her body?						Yes	No
c. Please confirm if the patient suffered from Third Degree (full thickness of the skin) burns covering at least 20% of the surface of his/her body?						Yes	No
d. Please confirm if the patient suffered from Third Degree burns covering at least 25% of his/her body surface?						Yes	No
e. Please confirm if the patient suffered from Third Degree (full thickness of the skin) burns covering at least 50% of his/her face?						Yes	No
7. Has the patient undergone any skin grafts to repair damaged skin?						Yes	No
a. If Yes, please state the date of skin grafting?		DD		MM		YYYY	
8. Has the patient undergone any surgical debridement under general anesthetic?						Yes	No
a. If Yes, please state the date of surgical debridement?		DD		MM		YYYY	
9. Please state other alternative of treatments patient has received, besides skin grafting and/or surgical debridement.							
Signature & Practice Stamp of the Medical Specialist who filled up Part II						Date	

Name of Patient:

NRIC / Passport No. of Patient:

SECTION 17 : MAJOR HEAD TRAUMA / FACIAL RECONSTRUCTIVE SURGERY OR SPINAL CORD INJURY / HEAD TRAUMA REQUIRING OPEN CRANIOTOMY / SURGERY FOR SUBDURAL HAEMATOMA

1. What is date of accident resulting in major head trauma?		DD		MM		YYYY
2. Where and how did the accident happened leading to major head trauma?						
3. Is there reason to suspect that there were contributory circumstances which led to the injury, e.g. under the influence of alcohol, drugs, fits, etc.?					Yes	No
If Yes, please provide details. (e.g. result of blood alcohol concentration, alcohol breath test; name of drugs, quantity consumed, etc.)						
4. Was there a police report made with regard to this accident? If Yes, please provide a copy.					Yes	No
5. Was the head injury due to a self-inflicted act?					Yes	No
6. Was the head injury due to participation or attempted participation in an unlawful act?					Yes	No
7. Was there any form of neurological deficit still present 6 weeks after the date of accident?					Yes	No
If Yes, please state the neurological deficits(s).						
8. Is the neurological deficit described in Q7 likely to be permanent (i.e. lasting throughout patient's lifetime)?					Yes	No
a. If Yes, please support your basis with evidence.		b. If No, please state date of recovery or date which the patient is expected to recover from neurological deficit. (DD/MM/YYYY)				
9. Did the patient suffered from facial injury? If Yes, please provide the following information:					Yes	No
a. What is date of accident resulting in facial injury?		DD		MM		YYYY
b. Where and how did the accident happen leading to facial injury?						
c. Please provide details of any facial injuries sustained.						
d. Was there any reconstructive surgery above the neck (restoration or reconstruction of the shape of, and appearance of facial structures which were defective, missing or damaged or misshapen) to correct disfigurement as a direct result of the accident?					Yes	No
i. If Yes, please provide dates and details of the surgery performed.						
e. Was the reconstructive surgery solely for treatment relating to teeth and/or any other dental restoration alone and/or cosmetic nose surgery?					Yes	No
10. Did the patient suffered from accidental cervical spinal cord injury? If Yes, please provide following:					Yes	No
a. What is date of accident resulting in cervical spinal cord injury?		DD		MM		YYYY
Signature & Practice Stamp of the Medical Specialist who filled up Part II					Date	

Name of Patient:

NRIC / Passport No. of Patient:

b. Where and how did the accident happen leading to cervical spinal cord injury?							
c. Please describe the exact nature of the cervical spinal cord injury sustained.							
d. Has the accidental cervical spinal cord injury resulted in the loss of use of at least one entire limb for at least 6 weeks from the accident?						Yes	No
i. If Yes, please describe and elaborate on the extent and severity of the patient's loss of use of his/her limb.							
11. Did patient undergo any surgery for treatment of head injury? If Yes, please provide the following:						Yes	No
a. What is the date of surgery?		DD		MM		YYYY	
b. Did patient undergo an open craniotomy surgery?						Yes	No
c. Did patient undergo burr hole surgery?						Yes	No
d. Has the patient undergone surgery for subdural hematoma? Please circle?						Yes	No
12. Was the subdural hematoma drained through a Burr Hole Surgery to the head?						Yes	No
13. If No, please state the treatment(s) provided?							
14. Was the cause of subdural hematoma a result of an accident??						Yes	No
i. If Yes, please state the date of accident (DD/MM/YYYY) and describe the circumstances how the accident occurred.				ii. If No, what is/are the underlying causes(s)?			
SECTION 18 : MAJOR ORGAN/ BONE MARROW TRANSPLANTATION / SMALL BOWEL TRANSPLANT OR CORNEAL TRANSPLANT/ MAJOR ORGAN OR BONE MARROW TRANSPLANT ON WAITLIST							
1. Date when illness/condition necessitating organ transplant was first diagnosed.		DD		MM		YYYY	
2. When did patient first become aware of the illness/condition requiring transplant?		DD		MM		YYYY	
3. What is the exact date of transplant?		DD		MM		YYYY	
4. Was the patient on official organ transplant waiting list for the receipt of a transplant of:							
a. human bone marrow using hematopoietic stem cells preceded by total bone marrow ablation; or						Yes	No
b. one of the human organs: heart, lung, liver, intestine, kidney or pancreas that resulted from irreversible end stage failure of the relevant organ						Yes	No
5. Was the patient a recipient of a human bone marrow transplant? If Yes, please advise:						Yes	No
a. Date the human bone marrow transplant was done.		DD		MM		YYYY	
b. Was the source of the transplanted bone marrow obtained from another human bone marrow?						Yes	No
c. Was the receipt of bone marrow transplant using haematopoietic stem cells preceded by total bone marrow ablation?						Yes	No
Signature & Practice Stamp of the Medical Specialist who filled up Part II						Date	

Name of Patient:

NRIC / Passport No. of Patient:

6. Was the patient a recipient of human organ transplantation? If Yes, please advise:					Yes	No
a. What is the exact date of organ transplant?		DD		MM		YYYY
b. Which human organ is transplanted?						
c. Was the transplant resulted from an irreversible end stage failure of the relevant organ?					Yes	No
d. What is the exact date the relevant organ has reached its end-stage?		DD		MM		YYYY
7. Was the patient a recipient of small bowel transplant? If Yes, please advise:					Yes	No
a. What is the exact date of small bowel transplant?		DD		MM		YYYY
b. Please confirm if there is receipt of at least one metre of small bowel transplanted via a laparotomy due to intestinal failure?					Yes	No
c. When is the onset date of patient's intestinal failure?		DD		MM		YYYY
8. Was the patient a recipient of a whole corneal transplant? If Yes, please advise:					Yes	No
a. What is the exact date of corneal transplant?		DD		MM		YYYY
b. Was the transplant due to irreversible scarring with resulting reduced visual acuity which cannot be corrected with other methods?					Yes	No
Please provide more details to your answer in Q8(b)						
9. Was there only surgery performed without any organ transplantation? (includes but not limited to bariatric surgery)					Yes	No
SECTION 19 : MOTOR NEURONE DISEASE / EARLY MOTOR NEURONE DISEASE OR SEVERE PERIPHERAL NEUROPATHY						
1. Please provide full and exact diagnosis of the patient's condition (including type of motor neurone disease e.g. amyotrophic lateral sclerosis, progressive bulbar palsy, spinal muscular atrophy and primary lateral sclerosis).						
2. Is the patient's motor neurone disease characterized by progressive degeneration of:						
a. corticospinal tracts?					Yes	No
b. anterior horn cells?					Yes	No
c. bulbar efferent neurons?					Yes	No
If Yes to any of the above, please provide more details to your answer.						
3. Please provide details of any investigations performed (e.g. electromyography, nerve conduction studies, MRI brain scan, muscle biopsy, spinal tap or lumbar puncture etc.). Please attach a copy of all investigation reports.						
4. Please describe in full details, including examination dates of the neurologic system, the extent and progression of patient's condition.						
Signature & Practice Stamp of the Medical Specialist who filled up Part II					Date	

Name of Patient:

NRIC / Passport No. of Patient:

5. Are the neurological deficits described in Q4 likely to be permanent?	Yes	No
Please provide more details to your answer.		
6. Is patient's condition peripheral neuropathy? If Yes, please advise:	Yes	No
a. If the peripheral neuropathy has resulted in significant motor weakness?	Yes	No
b. If the peripheral neuropathy has resulted in fasciculation?	Yes	No
c. If the peripheral neuropathy has resulted in muscle wasting?	Yes	No
d. Is the patient condition of peripheral neuropathy evident in nerve conduction studies?	Yes	No
e. Is there a permanent need for the use of walking aids or a wheelchair?	Yes	No
7. Is the patient's condition arising from diabetic neuropathy?	Yes	No
8. Is the patient's condition arising from excessive alcohol consumption?	Yes	No
If Yes to Q7 & Q8, please provide more details to your answer.		
SECTION 20 : MULTIPLE SCLEROSIS / EARLY MULTIPLE SCLEROSIS / MILD MULTIPLE SCLEROSIS		
1. Please provide details, including dates, of the extent of the patient's neurological deficit.		
2. Are there multiple neurological deficits which occurred over a continuous period of:		
a. at least 3 months?	Yes	No
b. at least 6 months?	Yes	No
If Yes to any of the above, please give details, including dates of each episode.		
3. Is there a well-documented history of repeated relapse and remission of a steady progressive disability?	Yes	No
If Yes, please provide details, including dates of each episode.		
4. Was the neurological damage caused by Systemic Lupus Erythematosus (SLE) or Human Immunodeficiency Virus (HIV)?	Yes	No
If Yes, please provide more details to your answer.		
5. Please provide details of any investigations performed and comment if the diagnosis was supported by objective test including blood test and MRI / CT scanning. Please attach a copy of all investigation reports		
Signature & Practice Stamp of the Medical Specialist who filled up Part II		Date

Name of Patient:

NRIC / Passport No. of Patient:

6. Please describe in full details, including examination dates, of the patient's current limitations in relation to his/her physical and mental state?

SECTION 21 : MUSCULAR DYSTROPHY / MODERATELY SEVERE MUSCULAR DYSTROPHY OR SPINAL CORD DISEASE OR INJURY RESULTING IN BOWEL AND BLADDER DYSFUNCTION

- | | | |
|---|-----|----|
| 1. Is there any evidence of sensory disturbance, abnormal cerebrospinal fluid, or diminished tendon reflex? | Yes | No |
|---|-----|----|

If Yes, please describe the findings.

2. What are the muscles involved?

- | | | |
|--|-----|----|
| 3. Was the diagnosis confirmed by an electromyogram? | Yes | No |
|--|-----|----|

- | | | |
|--|-----|----|
| 4. Was the diagnosis confirmed by muscle biopsy? | Yes | No |
|--|-----|----|

5. Is the patient able to perform (whether aided* or unaided) the following Activities of Daily Living?
*Aided shall mean with the aid of special equipment, device and/or apparatus and not pertaining to human aid.

Activity	Please circle if the patient can perform the listed activity?		Period of inability to perform	
			From (DD/MM/YYYY)	To (DD/MM/YYYY)
Washing : Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.	Yes	No		
Dressing : Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical or medical appliances.	Yes	No		
Transferring : Ability to move from a bed to an upright chair or wheelchair and vice versa.	Yes	No		
Mobility : Ability to move indoors from room to room on level surfaces.	Yes	No		
Toileting : Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.	Yes	No		
Feeding : Ability to feed oneself food once food has been prepared and made available.	Yes	No		

- | | | |
|---|-----|----|
| 6. Is the patient's condition spinal cord disease or cauda equina injury? | Yes | No |
|---|-----|----|

- a. If Yes, please advise which particular level or area of the spinal cord was affected by the disease or injury?

- | | | |
|--|-----|----|
| 7. Has the patient's neurologic condition resulted in permanent bowel dysfunction and bladder dysfunction?
If Yes, please advise: | Yes | No |
|--|-----|----|

- | | | |
|--|-----|----|
| a. Is there permanent dysfunction requiring permanent regular self-catheterisation or permanent urinary conduit? | Yes | No |
|--|-----|----|

- | | | |
|--|-----|----|
| b. Has the bowel and bladder dysfunction lasted for at least 6 months? | Yes | No |
|--|-----|----|

- | | | | | | | |
|---|--|----|--|----|--|------|
| i. If Yes to Q7(b), please provide exact date of onset. | | DD | | MM | | YYYY |
|---|--|----|--|----|--|------|

Signature & Practice Stamp of the Medical Specialist who filled up Part II

Date

Name of Patient:

NRIC / Passport No. of Patient:

SECTION 22 : PARALYSIS (IRREVERSIBLE LOSS OF USE OF LIMBS) / LOSS OF USE OF ONE LIMB / LOSS OF USE OF ONE LIMB REQUIRING PROSTHESIS

1. When was the date of onset?		DD		MM		YYYY
--------------------------------	--	----	--	----	--	------

2. Please state the limb(s) involved and the extent of loss of use:

Please circle the specific limbs involved	Please describe the extent of loss of use	Please circle if the loss of use total and irreversible	
Left Upper Limb		Yes	No
Left Lower Limb		Yes	No
Right Upper Limb		Yes	No
Right Lower Limb		Yes	No

3. If the loss of use of the involved limb(s) is total and irreversible, please provide more details to your answer in Q2 and advise the first date of such continuous loss of use.

4. Please confirm if the paralysis or loss of use of limb(s) has persisted for at least 6 weeks?

Yes	No
-----	----

a. Please provide the exact date of onset.

DD

MM

YYYY

5. Please confirm if the patient underwent fitting and use of prosthesis to the affected limb(s)?

Yes	No
-----	----

6. What was the underlying cause of patient's paralysis or loss of use of limb(s)?

a. If due to illness, please give full details including diagnosis and date of diagnosis.

b. If due to injury, please give full details including date of accident, how it happened and nature of injury.

7. Did the paralysis or loss of use of limb(s) resulting from a self-inflicted act?

Yes	No
-----	----

8. Did the paralysis or loss of use of limb(s) resulting from alcohol misuse?

Yes	No
-----	----

9. Did the paralysis or loss of use of limb(s) resulting from drug misuse?

Yes	No
-----	----

SECTION 23 : IDIOPATHIC PARKINSON'S DISEASE / EARLY AND MODERATELY SEVERE PARKINSON'S DISEASE

1. What is the cause of the patient's diagnosis of Parkinson's Disease?

2. Please confirm if the patient's diagnosis of Parkinson's Disease due to drug-induced causes?

Yes	No
-----	----

3. Please confirm if the patient's diagnosis of Parkinson's Disease due to toxic causes?

Yes	No
-----	----

4. Please confirm if the patient's diagnosis of Parkinson's Disease idiopathic in nature?

Yes	No
-----	----

5. Can the patient's condition be controlled with medication?

Yes	No
-----	----

If Yes, please give details of current treatment prescribed, including the name and dosage of medication, and date medical treatment first started.

Signature & Practice Stamp of the Medical Specialist who filled up Part II

Date

Name of Patient:

NRIC / Passport No. of Patient:

6. Are there signs of progressive impairment?			Yes	No
If Yes, please describe in details, including dates, of the extent of neurological deficit suffered by patient and how his/her condition has deteriorated over time.				
7. Is the patient able to perform (whether aided* or unaided) the following Activities of Daily Living? *Aided shall mean with the aid of special equipment, device and/or apparatus and not pertaining to human aid.				
Activity	Please circle if the patient can perform the listed activity?		Period of inability to perform	
			From (DD/MM/YYYY)	To (DD/MM/YYYY)
Washing : Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.	Yes	No		
Dressing : Ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical or medical appliances.	Yes	No		
Transferring : Ability to move from a bed to an upright chair or wheelchair and vice versa.	Yes	No		
Mobility : Ability to move indoors from room to room on level surfaces.	Yes	No		
Toileting : Ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene.	Yes	No		
Feeding : Ability to feed oneself food once food has been prepared and made available.	Yes	No		
8. Was the Parkinson's Disease a result from treatment for any other illness, or is it associated with any other disease, e.g. Wilson's Disease or Huntington's Chorea?			Yes	No
If Yes, please give full details including date of diagnosis, name and address of the doctor who made the diagnosis and source of information.				
SECTION 24: POLIOMYELITIS / SEVERE PERIPHERAL NEUROPATHY / MODERATELY SEVERE POLIOMYELITIS				
1. Was poliovirus the underlying cause of patient's condition?			Yes	No
a. If Yes, please provide details on poliovirus?		b. If No, what was the cause of patient's poliomyelitis?		
2. What is the current condition of the patient and what is the prognosis?				
3. Was there paralysis of the limb muscles?			Yes	No
If Yes, please describe the extent of patient's paralysis resulting from poliomyelitis.				
Signature & Practice Stamp of the Medical Specialist who filled up Part II			Date	

Name of Patient:

NRIC / Passport No. of Patient:

4. Was there paralysis of the respiratory muscles?	Yes	No
If Yes, please state if there was support by ventilator for a continuous period of minimum 96 hours	Yes	No
Please describe the impaired respiratory weakness resulting from poliomyelitis.		
5. For how long has the patient been suffering from the impaired motor function and/or respiratory weakness from its occurrence? Please attach a copy of the medical documentation.	months	
6. Is patient's condition peripheral motor neuropathy? If Yes, please advise:	Yes	No
a. If the peripheral neuropathy has resulted in significant motor weakness?	Yes	No
b. If the peripheral neuropathy has resulted in fasciculation?	Yes	No
c. If the peripheral neuropathy has resulted in muscle wasting?	Yes	No
d. Is the patient condition of peripheral neuropathy evident in nerve conduction studies?	Yes	No
e. Is there a permanent need for the use of walking aids or a wheelchair?	Yes	No
7. Is the patient's condition arising from diabetic neuropathy?	Yes	No
8. Is the patient's condition arising from excessive alcohol consumption?	Yes	No
If Yes to Q7 & Q8, please provide more details to your answer.		
SECTION 25 : PRIMARY PULMONARY HYPERTENSION / EARLY PULMONARY HYPERTENSION / SECONDARY PULMONARY HYPERTENSION / PULMONARY ARTERIAL HYPERTENSION		
1. Is the pulmonary hypertension due to primary cause?	Yes	No
2. Is the pulmonary hypertension due to secondary cause?	Yes	No
3. Were there presence of right ventricular hypertrophy, dilation and signs of right heart failure and decompensation?	Yes	No
4. Was there dyspnea and fatigue?	Yes	No
5. Was there increased left arterial pressure of at least 20mmHg?	Yes	No
6. Was there pulmonary resistance of at least 3 units above normal?	Yes	No
7. Was there pulmonary artery pressure of at least 40mmHg?	Yes	No
8. Was there pulmonary wedge pressure of at least 6mmHg?	Yes	No
9. Was there right ventricular end-diastolic pressure of at least 8mmHg?	Yes	No
10. Was cardiac catheterization performed to establish the pulmonary hypertension?	Yes	No
If Yes, please provide evidence of the investigation and attach a copy of the report.		
Signature & Practice Stamp of the Medical Specialist who filled up Part II		Date

Name of Patient:

NRIC / Passport No. of Patient:

11. Was there permanent physical impairment which fulfills the NYHA classification of cardiac impairment?	Yes	No
If Yes, please circle the appropriate class of impairment in accordance with the NYHA Classification of Cardiac Impairment:		
NYHA Class I	NYHA Class II	NYHA Class III
NYHA Class IV		
12. Please describe the patient's current symptoms / physical activity impairment in relation to his/her class of impairment.		
13. Please confirm if such impairments (as described in Q12) are likely to be permanent?	Yes	No
If Yes, please explain.		
SECTION 26 : PROGRESSIVE SCLERODERMA / EARLY PROGRESSIVE SCLERODERMA / PROGRESSIVE SCLERODERMA WITH CREST SYNDROME		
1. Please advise which form of scleroderma does the patient have?		
a. Localized scleroderma (linear scleroderma or morphea)	Yes	No
b. Eosinophilic fasciitis	Yes	No
c. CREST syndrome	Yes	No
d. Systemic scleroderma	Yes	No
If Yes to any of the above, please provide a description of the extent of the illness and the date of first diagnosis.		
2. Does the illness involve the followings:		
a. Skin with deposits of calcium (calcinosis)	Yes	No
b. Skin thickening of the fingers or toes (sclerodactyly)	Yes	No
c. The esophagus	Yes	No
d. Telangectasia (dilated capillaries)	Yes	No
e. Raynaud's Phenomenon causing artery spasms in the extremities	Yes	No
f. The heart	Yes	No
g. The lungs	Yes	No
h. The kidneys	Yes	No
Please provide more details to your answer above.		
Signature & Practice Stamp of the Medical Specialist who filled up Part II		Date

Name of Patient:

NRIC / Passport No. of Patient:

3. Please provide details of investigation performed, with dates, including biopsy and serological evidence.
Please attach a copy of the biopsy or equivalent confirmatory test and serology reports.

4. Please provide details of treatment prescribed, with dates (e.g. immunosuppressive therapy, anti-fibrotic agents, etc.).

SECTION 27 : SURGERY TO THE AORTA / MINIMALLY INVASIVE SURGERY TO AORTA OR LARGE ASYMPTOMATIC AORTIC ANEURYSM

1. On what date did the patient first become aware of the condition necessitating surgery?

	DD		MM		YYYY
--	----	--	----	--	------

2. What was the type of surgery performed? Please describe the surgical procedure in detail.

a. Was surgery performed to repair or correct an aneurysm?	Yes	No
b. Was surgery performed to repair or correct narrowing or obstruction of the aorta?	Yes	No
c. Was surgery performed to repair or correct dissection of the aorta?	Yes	No
d. Was surgery performed through surgical opening of the chest or abdomen?	Yes	No
e. Was surgery performed on the thoracic aorta?	Yes	No
f. Was surgery performed on the abdominal aorta?	Yes	No
g. Was surgery performed using minimally invasive or intra-arterial techniques?	Yes	No

If Yes to any of the above, please provide more details to your answer.

3. Please state exact date of surgery.

	DD		MM		YYYY
--	----	--	----	--	------

a. If surgery was not performed, please state degree of aortic aneurysm or dissection. Please attach a copy of tests results.

4. Please state which of the following condition does patient has:

a. Abdominal aortic aneurysm	Yes	No
b. Abdominal Aortic Dissection	Yes	No
c. Thoracic Aortic Aneurysm	Yes	No
d. Thoracic Aortic Dissection	Yes	No

Please provide details leading to the diagnosis of the abdominal or thoracic aortic aneurysm or dissection.

Signature & Practice Stamp of the Medical Specialist who filled up Part II

Date

Name of Patient:

NRIC / Passport No. of Patient:

5. Was there enlargement of the aorta?					Yes	No
If Yes, please state the diameter of the enlargement in millimeter.					mm	
6. Has the patient suffered or is suffering from any related illnesses e.g. hypertension, angina, vascular disease or endocarditis?					Yes	No
If Yes, please give date(s) of consultations and the resulting diagnosis.						
SECTION 28 : SYSTEMIC LUPUS ERYTHEMATOSUS WITH LUPUS NEPHRITIS / MILD SYSTEMIC LUPUS ERYTHEMATOSUS						
1. Did the patient present with any of the following conditions:						
a. malar rash					Yes	No
b. discoid rash					Yes	No
c. photosensitivity					Yes	No
d. oral ulcers					Yes	No
e. arthritis					Yes	No
f. serositis					Yes	No
g. renal disorder					Yes	No
h. leukopenia (<4,000/mL)					Yes	No
i. lymphopenia (<1,500/ mL)					Yes	No
j. haemolytic anaemia					Yes	No
k. thrombocytopenia					Yes	No
l. neurological disorder					Yes	No
2. Was the patient tested positive for any of the following tests:						
a. anti-nuclear antibodies					Yes	No
b. L.E. cells					Yes	No
c. anti-DNA					Yes	No
d. anti-Smith (Smith IgG autoantibodies)					Yes	No
3. Is patient currently receiving systemic lupus immunosuppressive therapy due to involvement of multiple organs? Please circle.					Yes	No
a. Please state the first treatment date of immunosuppressive therapy.				DD		MM
b. Since the commencement date of immunosuppressive therapy, has the therapy lasted for a period of at least 6 months? Please circle.					Yes	No
i. If No, what is the reason that it did not persist for a period of at least 6 months?						
Signature & Practice Stamp of the Medical Specialist who filled up Part II					Date	

Name of Patient:

NRIC / Passport No. of Patient:

4. Are the following internal organs involved:		
a. kidneys	Yes	No
b. brain	Yes	No
c. heart or pericardium	Yes	No
d. lungs or pleura	Yes	No
e. joints in the presence of polyarticular inflammatory arthritis	Yes	No
If Yes to any of the above, please describe the nature and extent of the impairment, with dates(s).		
5. Has the patient's Systemic Lupus Erythematosus lead to any kidneys involvement?		
	Yes	No
a. Was renal biopsy performed?	Yes	No
i. Please state the exact date biopsy was done and to elaborate on the biopsy result to establish the diagnosis of Systemic Lupus Erythematosus with Lupus Nephritis.		
b. Based on the biopsy results, please circle the appropriate staging of the patient's lupus nephritis in accordance with the RPS/ ISN Classification of Lupus Nephritis.		
Class I Minimal Mesangial Lupus Nephritis	Class II Mesangial Proliferative Lupus Nephritis	Class III Focal Lupus Nephritis (active and chronic; proliferative and sclerosing)
Class IV Diffuse Lupus Nephritis (active and chronic; proliferative and sclerosing; segmental and global)	Class V Membranous Lupus Nephritis	Class VI Advanced Sclerosis Lupus Nephritis
c. Based on the biopsy results, please circle the appropriate staging of the patient's lupus nephritis in accordance with the WHO Classification of Lupus Nephritis.		
Class 1 Minimal Change Lupus Glomerulonephritis	Class II Mesangial Lupus Glomerulonephritis	Class III Focal Segmental Proliferative Lupus Glomerulonephritis
Class IV Diffuse Proliferative Lupus Glomerulonephritis	Class V Membranous Lupus Glomerulonephritis	
d. Please state the creatinine clearance rate (e.g. mL per minute or less)		
6. Please provide details of the investigations/test performed and attach copies of the results that confirm patient's diagnosis and WHO classification of lupus nephritis. E.g. blood tests, urinalysis, ultrasound scans of the kidneys, and a kidney biopsy.		
7. Is the patient's condition a diagnosis of discoid lupus?	Yes	No
8. Is the patient's condition a diagnosis involving any form of hematologic abnormalities?	Yes	No
If Yes to Q5 &/or Q6, please provide details.		
Signature & Practice Stamp of the Medical Specialist who filled up Part II		Date

Name of Patient:

NRIC / Passport No. of Patient:

SECTION 29 : SEVERE ENCEPHALITIS / VIRAL ENCEPHALITIS WITH FULL RECOVERY / MODERATE VIRAL ENCEPHALITIS WITH FULL RECOVERY

1. What was the cause of the encephalitis (e.g. viral, bacterial etc) _____						
2. Was the patient hospitalized?					Yes	No
a. If Yes, please state the period of hospitalization.			From (DD/MM/YYYY)	To (DD/MM/YYYY)		
3. Did patient have any significant and serious permanent neurological deficits?					Yes	No
4. Are the permanent neurological deficits documented for at least 6 weeks?					Yes	No
On Q3 & Q4, please provide more details, including dates, on the extent and length of persistence of the deficits to your answer.						
5. Has the patient recovered to its normal functional state prior to the episode of encephalitis?					Yes	No
a. If Yes, please provide the exact date patient has returned to his/her normal activities.			DD	MM	YYYY	
6. Was the condition caused by HIV infections?					Yes	No
If Yes, please provide more details to your answer.						

SECTION 30 : Open Surgery of Major Organs

1. Did the patient underwent surgery for any of the following vital organs as a result of illness or an accident?						
a. Heart, heart valves and heart vessels (i.e. coronary arteries and aorta)					Yes	No
b. Brain and spinal cord					Yes	No
c. Lungs and mediastinum					Yes	No
d. Liver					Yes	No
e. Kidney					Yes	No
2. If the surgery was performed as a result of an illness, please provide details of the illness.						
Date of diagnosis of illness: _____ (DD/MM/YYYY)						
3. If the surgery was performed as a result of an accident, please provide details of how the accident happened.						
Date of accident: _____ (DD/MM/YYYY)						
Signature & Practice Stamp of the Medical Specialist who filled up Part II					Date	

Name of Patient:

NRIC / Passport No. of Patient:

4. Please state the nature of the surgery performed.

Date of surgery: _____ (DD/MM/YYYY)

5. Was the open surgery on major organs for diagnostic purposes only and not for therapeutic purposes?

Yes

No

6. Was the open surgery on major organs performed to harvest the organ for donation?

Yes

No

SECTION 31 : ICU Admission

1. Was the patient admitted to hospital due to result of surgery?

Yes

No

2. Was the patient admitted to hospital due to result of infection?

Yes

No

3. Was the patient admitted to the Intensive Care Unit (ICU) as a result of the surgery, for at least three continuous days?

Yes

No

4. Please state the period that the patient was hospitalized

From

(DD/MM/YYYY)

To

(DD/MM/YYYY)

5. Please state the period that the patient was in ICUs

From

(DD/MM/YYYY)

To

(DD/MM/YYYY)

SECTION 32 : BILIARY ATRESIA HAVING UNDERGONE LIVER TRANSPLANTATION / BILIARY ATRESIA (ON DIAGNOSIS)

1. Was patient's Biliary Atresia condition progressive, idiopathic, fibro-obliterative disease of the extra-hepatic biliary tree?

Yes

No

2. Did patient's Biliary Atresia condition present with Biliary Obstruction?

Yes

No

3. Did patient undergo liver transplantation?

Yes

No

4. If yes, please advise the date the surgery was performed

(DD/MM/YYYY)

5. Was patient on a registered liver transplantation waiting list?

Yes

No

6. Was patient's Biliary Atresia condition due to other diseases?

Yes

No

7. Please provide a copy of supporting evidence including imaging, laboratory tests and liver biopsy.

Yes

No

SECTION 33 : CREUTZFELD-JACOB DISEASE / LESS SEVERE CREUTZFELD-JACOB DISEASE / MODERATELY SEVERE CREUTZFELD-JACOB DISEASE

1. Did the incurable brain infection cause rapidly progressive deterioration of mental function and movement, which is unequivocally diagnosed by a consultant neurologist as Creutzfeldt-Jakob disease based on clinical assessment, EEG, imaging or lumbar puncture?

Yes

No

2. Has the patient's condition resulted in an associated neurological deficit?

Yes

No

3. Please describe the neurological deficit.

4. Is the neurological deficit permanent?

Yes

No

Signature & Practice Stamp of the Medical Specialist who filled up Part II

Date

Name of Patient:

NRIC / Passport No. of Patient:

5. Please advise if the deficit has resulted in the patient's inability to perform the Activities of Daily Living.

ADLs	Is the patient able to perform the ADL independently?	When did the patient became unable to perform such ADLs?	Is the inability to perform the ADL permanent?
Washing			
Dressing			
Transferring			
Mobility			
Toileting			
Feeding			

6. Was the disease caused by human growth hormone treatment?

Yes

No

SECTION 34 : MENINGEAL TUBERCULOSIS / TUBERCULOUS MYELITIS

1. Does the patient have meningitis caused by tubercle bacilli?

Yes

No

2. Did the condition result in permanent* neurological deficit?

Yes

No

If yes, please specify the neurological deficits suffered by the patient.

3. Was the evidence of permanent* clinical neurological deficit confirmed at least 6 weeks after the diagnosis of Meningeal tuberculosis?

Yes

No

4. Did the permanent* neurological deficit last for at least a continuous period of three (3) months?

Yes

No

5. Were there findings of M. tuberculosis infection confirmed on cerebrospinal fluid by lumbar puncture and CSF culture?

Yes

No

expected to last throughout the lifetime of the patient*SECTION 35 : NECROTISING FASCIITIS / EARLY STAGE NECROTISING FASCIITIS**

1. Were the usual/standard clinical criteria for necrotizing fasciitis met?

Yes

No

2. Was the bacterial identified a known cause of necrotizing fasciitis?

Yes

No

3. Were there widespread destruction of muscle and other soft tissues?

Yes

No

4. Did the widespread destruction result in a total and permanent loss of function in the affected body part?

Yes

No

Please specify the loss of function and the affected body part.

Signature & Practice Stamp of the Medical Specialist who filled up Part II

Date

Name of Patient:

NRIC / Passport No. of Patient:

5. Did the treatment of Necrotising Fasciitis required at least 96 hours intensive care unit (ICU) admission and total requiring at least 7 days hospital admission?			Yes	No
a) Please state the period that the patient was in ICU	(DD/MM/YYYY)	to	(DD/MM/YYYY)	
b) Please state the period that the patient was hospitalized	(DD/MM/YYYY)	to	(DD/MM/YYYY)	
SECTION 36 : PROGRESSIVE SUPRANUCLEAR PALSY / LESS SEVERE PROGRESSIVE SUPRANUCLEAR PALSY				
1. Was the occurrence of Progressive supranuclear palsy independent of all other causes?			Yes	No
2. Was the condition characterised by supranuclear gaze paresis, pseudobulbar palsy, axial rigidity and dementia?			Yes	No
3. Did it result in permanent neurological deficit?			Yes	No
If yes, please specify the neurological deficits suffered by the patient.				
4. Please advise if the deficit has resulted in the patient's inability to perform the Activities of Daily Living.				
ADLs	Is the patient able to perform the ADL independently?	When did the patient became unable to perform such ADLs?	Is the inability to perform the ADL permanent?	
Washing				
Dressing				
Transferring				
Mobility				
Toileting				
Feeding				
5. Were the conditions medically documented for at least 30 consecutive calendar days?			Yes	No
SECTION 37 : SEVERE EISENMENGER'S SYNDROME / LESS SEVERE EISENMENGER'S SYNDROME				
1. Was the reversed or bidirectional shunt a result of pulmonary hypertension caused by a heart disorder?			Yes	No
2. Was the patient symptomatic during ordinary daily activities despite the use of medication and dietary adjustment?			Yes	No
3. Was there evidence of abnormal ventricular function on physical examination and laboratory studies?			Yes	No
Please provide us with a copy of the laboratory results.				
4. Was there history of left to right shunt heart disease before the date of Diagnosis of Eisenmenger's Syndrome?			Yes	No
5. Was the diagnosis of left to right shunt heart disease supported by echocardiogram or other reliable imaging studies?			Yes	No
Please provide us with a copy of the echocardiogram or other reliable imaging studies.				
Signature & Practice Stamp of the Medical Specialist who filled up Part II			Date	

Name of Patient:

NRIC / Passport No. of Patient:

6. Was there evidence of reversed shunt (from left -right shunt to right -left shunt) newly occurred on the date of Diagnosis of Eisenmenger's Syndrome?	Yes	No
7. Did the Eisenmenger Syndrome progress to an irreversible stage and there is no any operation available to correct the abnormality?	Yes	No
8. Was there presence of permanent physical impairment classified as NYHA Class III?	Yes	No
9. Was there presence of permanent physical impairment classified as NYHA Class IV?	Yes	No

Please provide details of the NYHA classification in the table below:

New York Heart Association functional classification	What is the limitation in physical activity patient has?	What is patient's NYHA classification for the current condition? Please tick accordingly.	Is this limitation of physical activity permanent? Please circle.	
Class I			Yes	No
Class II			Yes	No
Class III			Yes	No
Class IV			Yes	No

SECTION 38 : MAFFUCCI SYNDROME

1. Was the diagnosis of Maffucci syndrome confirmed by a consultant orthopaedic surgeon?	Yes	No
2. Date of Diagnosis	(DD/MM/YYYY)	
3. Has the patient undergone surgery to correct two (2) or more skeletal deformities due to multiple enchondromas within the bones (enchondromatosis) and hemangiomas?	Yes	No
4. Date of surgery/procedure	(DD/MM/YYYY)	
5. Was the surgery medically necessary certified by the treating orthopaedic surgeon/specialist?	Yes	No

Please provide us with a copy of the Operation Report.

SECTION 39 : OLLIER'S DISEASE

1. Was the diagnosis of Ollier's Disease confirmed by a consultant orthopaedic surgeon?	Yes	No
2. Date of Diagnosis	(DD/MM/YYYY)	
3. Has the patient undergone surgery to correct two (2) or more skeletal deformities due to multiple enchondromas within the bones (enchondromatosis) and hemangiomas?	Yes	No
4. Date of surgery/procedure	(DD/MM/YYYY)	

Signature & Practice Stamp of the Medical Specialist who filled up Part II

Date

Name of Patient:

NRIC / Passport No. of Patient:

5. Was the surgery medically necessary certified by the treating orthopaedic surgeon/specialist?		Yes	No
Please provide us with a copy of the Operation Report.			
SECTION 40 : GUILLAIN-BARRE SYNDROME OF SPECIFIED SEVERITY			
1. Was the disorder of the peripheral nervous system caused by damage to the fatty insulating sheaths (myelin sheaths) of the nerves?		Yes	No
2. Was the diagnosis of Guillain-Barre Syndrome unequivocal and made by a neurologist via cerebrospinal fluid study, electromyogram, nerve conduction study or other equivalent tests?		Yes	No
Please provide us with a copy of the fluid study, electromyogram, nerve conduction study or other equivalent tests			
3. Did the diagnosis of Guillain-Barre Syndrome present with all of the following as confirmed by a specialist one (1) month after initial diagnosis of the disease:?		Yes	No
a) Hospital Admission		Yes	No
If Yes, please state the period that the patient was hospitalized		(DD/MM/YYYY)	to (DD/MM/YYYY)
b) Treatment with intravenous gamma globulins or plasma exchange?		Yes	No
c) Continuous endotracheal ventilation in an intensive care unit for a minimum of ten days		Yes	No
SECTION 41 : OTHER INFORMATION			
1. Has the patient's condition resulted in him/her to be physically or mentally disabled from ever continuing in any employment? If Yes, please state:		Yes	No
a. What were the patient's main physical or mental impairment and the severity of these limitations?			
b. What is your reason that the patient is incapable of any employment throughout his/her lifetime?			
c. In accordance to the Singapore's Mental Capacity Act (Cap 177A), is patient mentally incapacitated?		Yes	No
2. Is the patient's condition or surgery performed in any way related or due to:-			
a. AIDS, AIDS-related complex or infection by HIV?		Yes	No
b. Drug abuse or use of drug not prescribed by registered medical practitioner?		Yes	No
c. Alcohol abuse or misuse?		Yes	No
d. Congenital anomaly or defect?		Yes	No
e. Attempted suicide or self-inflicted injuries?		Yes	No
If Yes for any of the above, please provide the following details and also attach a copy of the test result.			
f. Please indicate the diagnosis date.		DD	MM YYYY
g. Name and practice address of the doctor who first diagnosed the patient with HIV, AIDS, drug abuse, alcohol abuse or congenital anomaly.			
Signature & Practice Stamp of the Medical Specialist who filled up Part II		Date	

Name of Patient:

NRIC / Passport No. of Patient:

3. Has the patient previously suffered from the condition described above or any related illness? If Yes, please provide the details below:				Yes	No
Diagnosis	Date of diagnosis	Date when patient was informed of diagnosis	Name and date of treatments	Name and address of treating doctor	
4. Is there anything in patient's medical history which would have increased the risk of his/her condition?				Yes	No
If Yes, please state the details.					
5. Does the patient have or ever had any other significant health condition? If Yes, please provide:				Yes	No
Diagnosis	Date of diagnosis	Date when patient was informed of diagnosis	Name and date of treatments	Name and address of treating doctor	

Name and Signature of the Medical Specialist who filled up Part II		Date
Practice Stamp of the Medical Specialist		

PART III

ATTACHMENT OF LABORATORY REPORTS

To enable us to proceed with the claim, it is mandatory to enclose all relevant clinical, radiological, histological, operation and laboratory reports by attaching them to this page.