Name of Patient	NRIC/Passport No. of Patient

SECTION 2 MEDICAL SPECIALIST REPORT

TOTAL AND PERMANENT DISABILITY / EARLY DISABILITY

(To be completed by Life assured's attending medical specialist.

Name of Specialist		MCR No.	
Field of Specialty			
Name of Medical Institution			

Part I

1. Date when patient first consulted you for the condition?		DD		MM		YY
2. When was the last consultation?		DD		MM		YY
3. What were the presenting symptoms when you first saw the patient?						
4. When did the above symptoms first present?		DD		MM		YY
If the date is unknown, please state how long the symptoms had been present prior to the date of first consultation.						
5. What were your clinical and physical/mental findings when you first saw patient?						
6. Please provide exact diagnosis :						
7. What is /are the underlying cause(s)?						

Signature & Practice Stamp of the Medical Specialist who filled up **Section 2**	Date

8. Date of diagnosis.		DD		MM		YY
9. Date the patient / patient's next of kin was informed of the diagnosis.		DD		MM		YY

10. What was the exact information regarding diagnosis that patient or patient's next-of-kin was informed of?

11. Please provide the details of patient's treatments (including any investigations/surgery administered) and his/her response to these treatments in chronological order. To **enclose copies** of the reports.

Date of treatment (dd/mm/yy)	Details of treatment	Investigation/Surgery	Patient's treatment progress

12. Please provide details of the medications prescribed and if any medicines have been titrated since the initial onset of disability.

13. Were you the doctor who **first** diagnosed the patient with this condition? Please circle.	Yes	No
14. If Yes, over what period do your records extend?	From (dd/mm/yy)	To (dd/mm/yy)

15. If you are not the first doctor who diagnosed the patient with this condition, please provide:

a. Name and 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		YY
c. When was the referral made for the patient to see you?		DD		MM		YY

d. What was the reason for referral to see you? Please attach a copy of the referral letter.

e. Please provide name and practice address of referral doctor.

Signature & Practice Stamp of the Medical Specialist who filled up **Section 2**	Date

PART II							
1. Date of last consultation		DD		MM		YY	
2. What were the symptoms and complaints reported by patient during the last consultation?							
3. What were your clinical and physical/mental findings when you last saw patient?							
4. Based on the last consultation assessment of patient's disability, please describe the nature and severity of patient's physical/mental impairment in respect of this illness or injury.							

5. As a result of the illness or injury, please state if patient's physical/mental impairment (as described in Question 4 above) had led to any of the following confinement requiring constant care and medical attention.

Type of Confinement	Please circle		Period of Confinement	
			From(dd/mm/yy)	To (dd/mm/yy)
a. Home (Please specify)	Yes	No		
b. Hospital (Please specify)	Yes	No		
c. Bed	Yes	No		
d. Wheelchair	Yes	No		
e. Others (Please specify)	Yes	No		

6. Is the patient able to perform (whether aided or unaided) the following Activities of Daily Living:

Activity	Please circle if the patient can perform the listed activity?		Period of inability to perform	
			From (dd/mm/yy)	To (dd/mm/yy)
Washing or bathing Ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means. e.g. to wash the back, to wash hair	Yes	No		
Dressing Ability to put on, take off, secure and unfasten all garments (upper and lower) and, as appropriate, any braces, artificial limbs or other surgical or medical appliances. e.g. to button clothes, to put on trousers	Yes	No		

Signature & Practice Stamp of the Medical Specialist who filled up **Section 2**	Date

Activity	Please circle if the patient can perform the listed activity?		Period of inability to perform	
			From (dd/mm/yy)	To (dd/mm/yy)
Feeding Ability to feed oneself food after it has been prepared and made available. e.g. to scoop food, to put food into mouth	Yes	No		
Toileting Ability to use the lavatory or manage bowel and bladder functions through the use of protective undergarments or surgical appliances if appropriate. e.g. to get on or off the toilet	Yes	No		
Transferring Ability to move from a lying position on the bed to an upright chair or wheelchair, and vice versa. e.g. to be lifted up from lying position to sitting position from bed	Yes	No		
Mobility Ability to move indoors from room to room on level surfaces. e.g. to be supervised by someone closely in case of fall	Yes	No		

7. Please evaluate patient's level of functional ability based on the date of last consultation.

Activity	Date of evaluation (dd/mm/yy)	Please circle if the patient can perform the activity?		Date from which help was required (dd/mm/yy)	Please provide details.
Walking Walk more than 200m on a level surface continuously within 5 minutes, without having to stop because of breathlessness or severe pain.		Yes	No		
Fine Hand Control To remove 5 paracetamol pills from a blister pack within 60 seconds using your hand(s).		Yes	No		
Siting and Rising from a chair To sit and rise to a standing position from a wheelchair or chair (both with arms) of 40cm to 45cm in height.		Yes	No		
Lifting and Carrying To lift (from a bench with a height of 1 metre) and carry a 2kg weight for 10m and then placing it back down at bench height.		Yes	No		
Communicating To hear sounds of below 60 decibels in all frequencies of hearing or the ability to speak with sufficient clarity. Please attach ENT report.		Yes	No		
Eyesight Vision is measured at 6/60 or worse in one of the eyes using a Snellen eye chart, when tested with visual aids. Please attach Opthalmologist report.		Yes	No		

Signature & Practice Stamp of the Medical Specialist who filled up **Section 2**	Date

8. To the best of your knowledge and Hospital records, what is the occupation and nature of duties reported by patient before he/she suffered the physical/mental incapacity?			
9. To what extent does his/her physical/mental incapacity prevent him/her from performing all the normal duties of his/her usual occupation?			
10. If he/she cannot return to his/her usual occupation, can he/she engage in any other types of occupation?		Yes	No
a. If Yes, please provide details for the following :-	b. If No, please provide details for the following		
i. When do you think the patient will be able to return to work, either part-time or full-time?	i. Give details on any social, domestic or employment issues that are, or have been, impacting the patient's ability to work?		
ii. What are the types of occupation he/she can engage in?	ii. Please describe how the physical/mental impairments prevent the patient from ever continuing in any occupation, business or activity which pays him/her an income.		
11. Is the patient suffering from total loss of hearing in both the ears? Please circle.		Yes	No
a. Please provide the actual readings on the extent of hearing loss for both ears. Please provide **copies of audiogram and sound-threshold tests**.			
Left ear loss of hearing: decibels	Right ear loss of hearing: decibels		
b. Is the hearing loss irreversible? Please circle.		Yes	No
12. Is the patient suffering from total loss of ability to speak? Please circle.		Yes	No
a. Is the loss of ability to speak as a result of injury or disease to the vocal cord? Please circle.		Yes	No
b. Is the loss of ability to speak total and irrecoverable? Please circle.		Yes	No
c. Did the inability to speak last for a continuous period of 12 months? Please circle.		Yes	No
d. Please state the period of inability to speak.	From (dd/mm/yy)	To (dd/mm/yy)	
e. Is the loss of ability to speak associated with any psychiatric condition? Please circle		Yes	No

Signature & Practice Stamp of the Medical Specialist who filled up **Section 2**	Date

13. Is the patient suffering from total and irrecoverable loss of use of both eyes? Please circle.	Yes	No
Please explain in details.		
14. Is the patient suffering from total and irrecoverable loss of use of any two limbs, excluding hands and feet? Please circle.	Yes	No
Please explain in details.		
15. Is the patient suffering from total and irrecoverable loss of use of one eye and any one limb excluding hands and feet? Please circle.	Yes	No
Please explain in details.		
16. In accordance to the Singapore's Mental Capacity Act (Cap 177A), is the patient mentally incapacitated? Please circle.	Yes	No

PART III

1. Is the patient's disability arising directly or indirectly out of:	Please circle.	
a. attempted suicide or self-inflicted injuries?	Yes	No
b. AIDS, AIDS-related complex or infection by HIV?	Yes	No
c. congenital or hereditary diseases or disorder?	Yes	No
d. mental and personality disorders (excluding Dementia and Alzheimer's disease)?	Yes	No
e. improper use of alcohol, alcohol abuse or alcohol dependence?	Yes	No

If you have answered Yes to any of the above Question 1(a) to 1(e), please provide details:

Diagnosis	Date of diagnosis (dd/mm/yy)	Name and address of treating doctor

2. Has the patient previously consulted you or any other doctor for treatment or advice for this disability condition or any related condition? If yes, please provide the following details:	Yes	No

Diagnosis	Date of diagnosis (dd/mm/yy)	Date when patient was informed of diagnosis	Name and date of treatments	Name and address of treating doctor

Signature & Practice Stamp of the Medical Specialist who filled up **Section 2**	Date

3. Does the patient have or ever had any other significant health condition? If Yes, please provide following details:				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 **Section 2**	Date
Practice Stamp of the Medical Specialist	

SECTION 3
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.

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