DOCTOR'S STATEMENT
(Total and Permanent Disability)
To be completed by the patient's attending doctor

A. Patient's particulars

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

B. Patient's medical records

1. Please state the period of patient's record with the Hospital/Clinic?

   a. Date of first consultation _____(dd/mm/yyyy)

   b. Date of last consultation _____(dd/mm/yyyy)

   c. Date of next review _____(dd/mm/yyyy)

   Please provide reason for consultations:

Consultation date	Reason for consultation

2. Are you the patient's regular doctor? ☐ Yes ☐ No

   If Yes, since when? _____(dd/mm/yyyy)

   If No, please provide the Name and Address of the patient's regular doctor (if known to you):

   _____

3. Was the patient referred to you? ☐ Yes ☐ No
   If Yes, please provide details:

Date of referral	Reason for referral	Name and Address of doctor referred to

4. Have you referred the patient to other doctor/hospital/clinic? ☐ Yes ☐ No
   If Yes, please provide details:

Date of referral	Reason for referral	Name and Address of doctor referred to

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5. Does the patient have any family history? ☐ Yes ☐ No
If Yes, please provide details:

Age at onset	Relationship to the patient	Nature of Condition

6. Does the patient have any other significant health conditions, medical history or any illnesses (e.g. hypertension, diabetes, hyperlipidaemia, tumour, hepatitis etc)? ☐ Yes ☐ No

If Yes, please provide details:

Diagnosis Date	Diagnosis & Treatment	Name and address of doctor who treated patient

7. Please give details of the patient's habits in relation to cigarette smoking.

No. of years of smoking	No. of sticks per day	Source of information

8. Please give details of the patient's habit in relation to alcohol consumption.

Type	Quantity	Frequency (per week / month)	Source of Information

C. Cause of Condition (if due to illness)

1. When did patient first consult a doctor for the condition? _____(dd/mm/yyyy)

2. Please state symptoms presented and the date symptoms first appeared:

Symptoms Presented	Date symptoms first appeared	Source of information (Patient / Referring doctor* / others*) **Please specify name and address of source*

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3. In your opinion, how long do you think the patient has actually experienced these symptoms?

_____

_____

4. What was the underlying cause of the symptoms/condition?

_____

_____

5. What was the exact diagnosis?

_____

_____

6. When was the date of diagnosis? _____(dd/mm/yyyy)

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

8. Please provide details of the doctor who first made the diagnosis:

Name of doctor / specialist	Address of doctor / specialist

9. Please provide details and results of all investigation / tests performed and attach a copy of them which confirmed the diagnosis:

Investigation / tests	Date (dd/mm/yyyy)	Result of investigation / tests

10. If the patient is hospitalised due to the condition, please provide details:

Name of doctor/specialist	Address of hospital	Period of hospitalisation

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11. Was the patient under the influence of alcohol? ☐ Yes ☐ No

If Yes, what was the blood alcohol content? _____

12. Was the patient under the influence of any other drugs? ☐ Yes ☐ No

If Yes, please provide name of drugs and results of any blood tests performed.

_____

_____

13. Is the condition self-inflicted? ☐ Yes ☐ No

If Yes, please provide details:

_____

_____

14. Please provide details on treatment provided.

Start of treatment date	End of treatment date	Treatment prescribed

D. Cause of Condition (if due to accident)

15. Please provide information on how the accident happened.

_____

_____

_____

16. Date of accident _____(dd/mm/yyyy)

17. Place of accident _____

18. Please describe the injuries sustained by the patient.

_____

_____

_____

19. Was the patient under the influence of alcohol at the time of accident? ☐ Yes ☐ No

If Yes, what was the blood alcohol content? _____

20. Was the patient under the influence of any other drugs? ☐ Yes ☐ No

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If Yes, please provide name of drugs and results of any blood tests performed.

_____

_____

21. Is the condition self-inflicted? ☐ Yes ☐ No

If Yes, please provide details:

_____

_____

22. Please describe the type of treatment provided.

Start of treatment date	End of treatment date	Treatment prescribed

E. Detail of Condition

23. What were the symptoms and complaints reported by patient during last consultation?

_____

_____

_____

_____

24. What were your clinical, physical and mental findings when you last saw patient?

_____

_____

_____

_____

25. Based on the last consultation assessment of patient's disability, please give details of the nature and severity of physical and mental impairment(s) of patient's condition.

_____

_____

_____

_____

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26. Has the patient suffered from total and irrecoverable (permanent) loss of sight? ☐ Yes ☐ No

If Yes, please provide details:

a. Which eye(s) is/are affected? ☐ Left ☐ Right ☐ Both

b. What is the clinical basis for the diagnosis of total and irrevocable (permanent) loss of sight?

_____

_____

c. If the patient has suffered total and irrevocable (permanent) loss of sight of both eyes, has the patient been certified legally blind? ☐ Yes ☐ No

27. Has the patient suffered from total and irrevocable (permanent) loss of use of any limb? ☐ Yes ☐ No

If Yes, please provide details:

Affected limb	Details of disability	
☐ Right Arm above the wrist	When did the total and irrevocable loss of use start?	_____(dd/mm/yyyy)
	Is the loss of use due to amputation?	☐ Yes ☐ No If Yes, please state the amputation date: _____(dd/mm/yyyy)
	Is the loss of use due to functional impairment including paralysis or stiffness of joints?	☐ Yes ☐ No If Yes, please provide details on cause of impairment: _____ _____ _____
☐ Left Arm above the wrist	When did the total and irrevocable loss of use start?	_____(dd/mm/yyyy)
	Is the loss of use due to amputation?	☐ Yes ☐ No If Yes, please state the amputation date: _____(dd/mm/yyyy)
	Is the loss of use due to functional impairment including paralysis or stiffness of joints?	☐ Yes ☐ No If Yes, please provide details on cause of impairment: _____ _____ _____

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☐ Right Leg above the ankle	When did the total and irrevocable loss of use start?	_____(dd/mm/yyyy)
	Is the loss of use due to amputation?	☐ Yes ☐ No If Yes, please state the amputation date: _____(dd/mm/yyyy)
	Is the loss of use due to functional impairment including paralysis or stiffness of joints?	☐ Yes ☐ No If Yes, please provide details on cause of impairment: _____ _____ _____
☐ Left Leg above the ankle	When did the total and irrevocable loss of use start?	_____(dd/mm/yyyy)
	Is the loss of use due to amputation?	☐ Yes ☐ No If Yes, please state the amputation date: _____(dd/mm/yyyy)
	Is the loss of use due to functional impairment including paralysis or stiffness of joints?	☐ Yes ☐ No If Yes, please provide details on cause of impairment: _____ _____ _____

28. Did the disability persist for a continuous period of at least 6 months from date of disability? ☐ Yes ☐ No

29. Is the disability permanent? ☐ Yes ☐ No

30. Is his/her disability progressive, stationary or improving? _____

31. Has there been any improvement since you first saw patient?

_____

_____

32. Is the patient following the recommended treatment program? ☐ Yes ☐ No
Please provide details including nature of treatment.

_____

_____

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33. Is full recovery expected? ☐ Yes ☐ No

If Yes, please provide approximate date: _____(dd/mm/yyyy)

34. Is there a history of this condition or any condition likely to have contributed or to be connected with patient's present condition? ☐ Yes ☐ No

If Yes, please provide details including diagnosis, dates of diagnosis & consultations etc:

_____

_____

35. Is the patient able to perform (whether aided* or unaided) the following Activities of Daily Living?

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

Activity	Can patient perform the 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 any 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 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 once food has been prepared and made available.	☐ Yes ☐ No		

36. Please state if patient's impairment(s) had led to any of the following confinement requiring constant care and medical attention.

Confinement		Period of confinement	
		From (dd/mm/yyyy)	To (dd/mm/yyyy)
a. Home *Please specify:*	☐ Yes ☐ No		
b. Hospital / Institution *Please specify:*	☐ Yes ☐ No		
c. Bed	☐ Yes ☐ No		

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Confinement		Period of confinement	
		From (dd/mm/yyyy)	To (dd/mm/yyyy)
d. Wheelchair	☐ Yes ☐ No		
e. Others *Please specify:*	☐ Yes ☐ No		

F. Detail of Patient's Occupation

37. What is the occupation and nature of duties reported by patient before he/she suffered from the disability?

Occupation before disability	Main tasks and duties	Minor tasks and duties

38. Has the impairment(s)/disability prevented the patient from continuing his/her usual occupation? ☐ Yes ☐ No

If Yes, please provide details:

a. When did the patient become disabled such that he/she cannot continue in his/her occupation? _____(dd/mm/yyyy)

b. To what extent does the impairment(s)/disability prevent him/her from continuing his/her occupation.

_____

_____

_____

c. Is the patient's inability to perform his/her occupation permanent? ☐ Yes ☐ No

If No, please provide the date when patient is expected to return to his/her occupation: _____(dd/mm/yyyy)

If No, please provide details:

a. Is the patient totally unable to perform the main duties as mentioned in question 37? ☐ Yes ☐ No

If Yes, please provide details:

i. Please elaborate how the impairment(s)/disability prevent the patient from performing the main duties.

_____

_____

_____

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ii. Date when patient become totally unable to perform the main duties: _____(dd/mm/yyyy)

iii. Date when patient is expected to return to work to perform the main duties: _____(dd/mm/yyyy)

39. If patient cannot return to his/her usual occupation, can he/she engage in any other types of occupation? ☐ Yes ☐ No

If Yes, please provide details:

a. What are the types of occupation he/she can engage in?

_____

_____

b. When is he/she expected to engage in these occupations? _____(dd/mm/yyyy)

If No, please provide details:

a. Details on any social, employment issues that are or have been impacting patient's ability to work.

_____

_____

_____

b. Please describe how the impairment(s) prevent the patient from ever continuing in any occupation, business or activity for income, remuneration or profit.

_____

_____

_____

c. Please state the date when patient cannot engage in any occupation, business or activity which pays an income. _____(dd/mm/yyyy)

40. Was the patient's condition in any way related or due to:

a. Alcohol abuse/misuse? ☐ Yes ☐ No

b. Drug abuse/misuse or use of drug not prescribed by registered medical practitioner? ☐ Yes ☐ No

c. Presence of AIDS or HIV infection? ☐ Yes ☐ No

d. Congenital anomaly or defect? ☐ Yes ☐ No

e. Attempted suicide or self-inflicted injuries? ☐ Yes ☐ No

f. Donation of any of his/her organs? ☐ Yes ☐ No

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If Yes to above, please provide details:

Diagnosis date	Diagnosis	Name and address of doctor who treated patient

G. Other Information

1. Has the patient previously suffered from condition(s) specified above or any possible related illnesses? ☐ Yes ☐ No

   If Yes, please provide details:

Diagnosis date	Diagnosis	Name and address of doctor who treated patient

2. Is the patient mentally incapacitated in accordance to the Mental Capacity Act (Chapter 177A of Singapore)? ☐ Yes ☐ No

   Please describe his/her mental and cognitive abilities.

   _____

3. Please provide us with any other additional information that will assist us in assessing the claim.

   _____

H. Medical reports

Please attach copies of the following reports:

- All diagnostic investigation including X-ray, CT/MRI/imaging scans, operation report etc.
- All relevant hospital/surgical, laboratory and test results.

I. Details of attending Doctor

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

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