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an NTUC Social Enterprise

Attending Medical Practitioner's Statement

Part 1 (To be completed by Insured)

Name of Insured (as shown in NRIC)		NRIC number
Name of next-of-kin (if Insured is below age 21 or deceased)	Relationship to Insured	NRIC number

Declaration and Authorisation
1. I confirm that I have agreed to the "Personal Data Collection Statement" provided in the Medical/Accident/Living/Total & Permanent Disability claim form.
2. I agree and authorise:
   (a) Any medical institution or medical practitioner to release to Income any information as requested by Income; and
   (b) Income to release any relevant information concerning me/my child to any medical institution or medical practitioner.

A photocopy of this form is valid as an original copy.

Signature/Thumbprint of Insured/next-of-kin[1] | Date (dd/mm/yyyy)

[1] Please delete accordingly

Parkinson's Disease
Part 2 (To be completed by Doctor)

Name of Insured (as shown in NRIC)	NRIC number

A. General information

1. (a) Are you the Insured's usual doctor? ☐ Yes ☐ No

   (b) Over what period do your records extend?

   Start date (dd/mm/yyyy) _____ /_____ /_____ End date (dd/mm/yyyy) _____ /_____ /_____

2. When did the Insured first consult you for this condition? (dd/mm/yyyy): _____ /_____ /_____

3. When you first saw the Insured, what were the symptoms presented and their duration? Please state date of onset of symptoms.

Symptoms presented	Duration of symptoms	Date symptoms first occurred (dd/mm/yyyy)

What/who is the source of this information?

4. Did the Insured consult any other doctors for this illness or its symptoms before he/she consulted you? ☐ Yes ☐ No
   If "Yes", please provide details.

Name of doctor	Name and address of clinic/hospital	Date(s) of consultation (dd/mm/yyyy)	Diagnosis made

Parkinson's Disease
Part 2 (To be completed by Doctor) (continued)

B. Details of dread disease

5. (a) What is the diagnosis?

(b) Date of diagnosis (dd/mm/yyyy): _____ /_____ /_____

(c) Please provide the name and address of doctor and clinic/hospital where the diagnosis was first made.

(d) Please provide the date when the Insured was first informed of the diagnosis (dd/mm/yyyy): _____ /_____ /_____

(e) Is the Parkinson's disease: (i) idiopathic in nature	☐ Yes ☐ No
(ii) drug-induced	☐ Yes ☐ No
(iii) toxic-caused	☐ Yes ☐ No

If "Yes" to any of the above, please provide details including date of diagnosis, name and address of the neurologist who made the diagnosis and source of information.

(f) Did the Parkinson's disease result from treatment for any other illness, or is it associated with any other disease, e.g. Wilson's Disease or Huntington's Chorea? If "Yes", please give full details including date of diagnosis, name and address of the doctor who made the diagnosis and source of information.	☐ Yes ☐ No

6. (a) Please provide details, including dates and the extent of neurological deficit suffered.

(b) Can the condition be controlled with medication? Please state date when medical treatment first started _____ /_____ /_____	☐ Yes ☐ No
(c) Are there signs of progressive impairment? If "Yes", please provide details.	☐ Yes ☐ No

Parkinson's Disease
Part 2 (To be completed by Doctor) (continued)

(d) Please tick as applicable in relation to the Insured's ability to perform the Activities of Daily Living, whether aided with special equipment or unaided.

Activity	Need someone to help throughout the entire activity	Period which help was required	
		From (dd/mm/yyyy)	To (dd/mm/yyyy)
Washing or bathing 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 appliances.	☐ Yes ☐ No		
Feeding Ability to feed oneself once food has been prepared and made available.	☐ 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		
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		

7. Please provide full details of all treatment provided, including dates and duration of each treatment.

Type of treatment	Date of treatment (dd/mm/yyyy)	Duration of treatment

8. Please provide details of all investigations/tests performed and attach copies of results of any investigations performed, e.g. neurological examination, CT/MRI and any other imaging studies, laboratory evidence etc. and other relevant hospital reports.

9. Please provide details of all doctors and clinics/hospitals to which the Insured has been referred to or attended for this condition.

Name of doctor	Name and address of clinic/hospital	Date(s) of consultation (dd/mm/yyyy)	Diagnosis made

Parkinson's Disease
Part 2 (To be completed by Doctor) (continued)

C. Medical History

10. Has the Insured previously suffered from the above illnesses or any related illnesses?
If "Yes", please provide details, including date of diagnosis, name and address of doctor/clinic and source of information.

☐ Yes ☐ No

11. Please give details of the Insured's medical history which would have increased the risk of Parkinson's disease (including nature of illness, date of diagnosis and source of information).

12. Please give details of the Insured's family history which would have increased the risk of Parkinson's disease (including the relationship, nature of illness, date of diagnosis and source of information).

13. Please give details of the Insured's habits in relation to past and present smoking, including the duration of smoking habits, number of cigarettes smoked per day and source of this information.

14. Please give details of the Insured's habits in relation to alcohol consumption, including the amount of alcohol consumption per day and source of this information.

15. Does the Insured have or ever had any other significant health condition(s)?
If "Yes", please provide details.

☐ Yes ☐ No

Diagnosis	Name of doctor	Name and address of clinic/hospital	Date of diagnosis (dd/mm/yyyy)	Duration of condition	Treatment received

D. Additional Information

16. Please provide us with any other additional information that will enable us to assess this claim.

Signature of doctor

Date (dd/mm/yyyy)

Name and qualification (printed)

Address and official stamp of clinic/hospital