中国人寿保险(新加坡)有限公司
China Life Insurance (Singapore) Pte. Ltd.

CRITICAL ILLNESS CLAIM FORM
Other Critical Illness

Dear Claimant

We are sorry to learn of the Life Insured's illness.

In order for us to process the claim, please provide the following:

1. Claimant's Statement (Section A of the Critical Illness Claim Form)
2. Medical Specialist Report (Section B of the Critical Illness Claim Form)
3. Copies of all diagnostic reports (e.g Histopathology report, MRI report, Troponin test results) detailed Inpatient Discharge Summary and any relevant hospital reports that are available
4. Copy of Life Insured's NRIC or Passport
5. Copy of the NRIC/FIN or Passport of the Policy Owner, if different from Life Assured

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 acceptance of this form is not an admission of liability by China Life Insurance (Singapore) Pte. Ltd. ("CLIS","our", "us", "we").
3. All documents submitted must be in English. Any document which is in foreign language must be translated to English by a certified translator.
4. Any expense that is incurred in obtaining any of the documents required, including but not limited to the Specialist Report or medical evidences, for claim filing shall be borne by you.
5. Please submit all required documents and we will assess the claim upon receipt of all the required documents and advise whether medical reports or further documentary evidences are required.
6. The Company may communicate with you with regard to this claim by email and/or letter by post.

Submission of Documents

You may submit the claim documents personally at our Customer Care Centre, through your financial adviser representative or by post to:

Claims Department
China Life Insurance (Singapore) Pte. Ltd.
1 Raffles Place #46-00 One Raffles Place Tower 1
Singapore 048616

If you have any queries, please call us at Customer Care Hotline at (65) 6727 4800 or email us at Customercare@chinalife.com.sg.

SECTION A – CLAIMANT'S STATEMENT

(to the completed by the Life Insured who is at least 18 years old or Policy Owner if the Life Insured is below 18 years old)

1) POLICY NUMBER(S)

2) INFORMATION OF LIFE INSURED

Full Name (as shown in NRIC/ Passport)	
NRIC / FIN / Passport Number	
Date of Birth (dd/mm/yyyy)	
Gender	☐Female ☐Male
Marital Status	
Mailing Address	
Contact Number	
Email Address	
Occupation	
Name and Address of Employer	

3) DETAILS OF ILLNESS/ MEDICAL CONDITION

1. Describe fully the signs or symptoms for which Life Insured has consulted doctor or received treatment.	
2. Date when signs or symptoms first started. (dd/mm/yyyy)	
3. Date when Life Insured first consulted a doctor for the above signs or symptoms. (dd/mm/yyyy)	
4. Please provide the following details accordingly if the consultation was due to illness or accident.	
a. If consultation was for illness, describe fully the nature and extent of illness in terms of its diagnosis and treatment received.	
b. If consultation was due to accident, describe fully the date of accident, how and where did the accident occur?	
c. Was the accident reported to the police?	☐ Yes ☐ No
d. If yes, please provide a copy of the police report.	
5. Has Life Assured previously suffered from or received treatment for a similar or related illness / injury?	☐ Yes ☐ No
If yes, please give details.	

6. Please provide the details of all doctors or specialists whom Life Insured has consulted in connection with his/ her illness/ injury:

Name of Doctor	Name and Address of Clinic/ Hospital	Date of Consultation (dd/mm/yyyy)	Reason(s) for Consultation

7. Please provide the name and address of Life Insured's regular doctor and company doctor for **ALL** other medical conditions(s):

Name of Doctor	Name and Address of Clinic/ Hospital	Date of Consultation (dd/mm/yyyy)	Reason(s) for Consultation

4) OTHER INSURANCE

1. Does Life Insured have similar benefits with other insurers? ☐ Yes ☐ No

If yes, please provide details below:

Name of Insurer	Type of Plan	Date of Issue (dd/mm/yyyy)	Sum Insured

5) SETTLEMENT OPTION FOR APPROVED CLAIM

☐ PayNow NRIC No : _____
(Your Singapore NRIC/FIN number must be linked to a PayNow account)

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 No.

☐ Direct credit into my bank

Name of Bank : _____

Account Number:_____

Please fill in your bank details and **submit a copy of the policyowner's bank book or bank statement, stating the account holder's name and account number**. We accept bank statements with the bank balances and transactions being blacked out, and truncated e-statements downloaded from the banks' mobile application, provided that the document shows the account holder's name and account number on the same page.

Important note
To avoid delay in payment,
(1) please ensure that you have signed up for PayNow with your bank by linking it to your NRIC/FIN No.
(2) please ensure that your bank details are accurate and matches your bank records. We do not allow 3rd party payment.

6) AUTHORISATION AND 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 China Life Insurance (Singapore) Pte. Ltd. ("CLIS") 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 policyowner 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 CLIS, 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 CLIS 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 CLIS 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 CLIS for verification as it deems necessary.

8. I expressly authorise and consent to CLIS and its officers, employees and representatives collecting from, using and disclosing to any of the following persons, whether in Singapore or elsewhere, at their sole discretion, any and all information relating to the policyowner and the insured(s), including personal particulars, transactions and dealings with CLIS,:

   a) any doctor, hospital, clinic, insurance company;
   b) CLIS's holding companies, branches, representative offices, subsidiaries, related corporations or affiliates;
   c) any of CLIS's contractors or third party service providers or distribution partners or professional advisers or representatives; and
   d) any regulatory, supervisory or other authority, court of law, tribunal or person, in any jurisdiction, where such disclosure is required by law, regulation, judgement or order of court or order of any tribunal or as a matter of practice,

   for the purpose of processing, investigating and assessing this claim.

   I understand that CLIS has a Personal Data Protection Policy, which sets out the purposes for which personal data may also be used and disclosed, and it is available at www.chinalife.com.sg, which I confirm I have read and understood.

9. I agree to indemnify CLIS for all losses and damages that CLIS may suffer in the event that I am in breach of any representation and warranty provided to me herein.

I agree that this (i) CLIS 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.

_____

Name and Signature of Policy Owner/ Life Insured
(Policyholder to sign if Life Insured is a minor)

_____ _____

NRIC/ FIN/ Passport Number | Date (dd/mm/yyyy)

SECTION B – SPECIALIST REPORT

Other Critical Illness

(To be completed by the Life Assured's attending medical specialist)

Important Notes:
In order for us to process the claim, please submit all relevant clinical, radiological, histological, operation (if surgery has been performed), laboratory reports and other reports as follows with this Specialist Report:

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

Critical Illness	Parts to be completed	Critical Illness	Parts to be completed
☐ Alzheimer's Disease / Severe Dementia	1, 2 & 3	☐ Major Burns	1, 2 & 17
☐ Persistent Vegetative State (Apallic Syndrome)	1, 2 & 4	☐ Major Head Trauma	1, 2 & 18
☐ Irreversible Aplastic Anaemia	1, 2 & 5	☐ Major Organ / Bone Marrow Transplantation	1, 2 & 19
☐ Severe Bacterial Meningitis	1, 2 & 6	☐ Motor Neurone Disease	1, 2 & 20
☐ Blindness (Irreversible Loss of Sight)	1, 2 & 7	☐ Multiple Sclerosis	1, 2 & 21
☐ Coma	1, 2 & 8	☐ Muscular Dystrophy	1, 2 & 22
☐ Deafness (Irreversible Loss of Hearing)	1, 2 & 9	☐ Paralysis (Irreversible Loss of Use of Limbs)	1, 2 & 23
☐ End Stage Liver Failure	1, 2 & 10	☐ Idiopathic Parkinson's Disease	1, 2 & 24
☐ End stage Lung Disease	1, 2 & 11	☐ Poliomyelitis	1, 2 & 25
☐ Fulminant Hepatitis	1, 2 & 12	☐ Primary Pulmonary Hypertension / Pulmonary Arterial Hypertension	1, 2 & 26
☐ Open Chest Heart Valve Surgery	1, 2 & 13	☐ Progressive Scleroderma	1, 2 & 27
☐ HIV Due to Blood Transfusion and Occupationally Acquired HIV	1, 2 & 14	☐ Open Chest Surgery to Aorta	1, 2 & 28
☐ Loss of Independent Existence	1, 2 & 15	☐ Systemic lupus erythematosus with lupus nephritis	1, 2 & 29
☐ Irreversible Loss of Speech	1, 2 & 16	☐ Severe Encephalitis	1, 2 & 30

Name, Signature and Practice Stamp of the Specialist who complete Section B	Date

PART 1: INFORMATION ON SPECIALIST AND PATIENT

INFORMATION ON SPECIALIST

Name of Specialist	
Field of Speciality	
Name of Medical Institution	

INFORMATION AND MEDICAL RECORDS OF PATIENT

Name of Patient (as shown in NRIC/ Passport)	
NRIC / FIN / Passport Number	
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 the 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)	
Name, Signature and Practice Stamp of the Specialist	Date

9. Please provide dates and details of the investigation for the diagnosis. Please **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 to Question 10, over what period do your records extend? (dd/mm/yyyy)	From	To
12. If you are not the first doctor who diagnosed that 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/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.		
e. Please provide name and address of referral doctor.		
Name, Signature and Practice Stamp of the Specialist	Date	

PART 2: 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
e. Congenital anomaly or defect?	☐ Yes ☐ No
d. Attempted suicide or self-inflicted injuries?	☐ Yes ☐ No
If Yes to any of the above, please provide the following details and also attach a copy of the test results.	
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.	

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

Name, Signature and Practice Stamp of the Specialist	Date

PART 3: ALZHEIMER'S DISEASE / SEVERE DEMENTIA

1. Is there evidence of deterioration or loss of cognitive function?	☐ Yes ☐ No
2. Is there abnormal behaviour 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 behaviour.	
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 tick your reply if the patient's deterioration or loss of intellectual capacity or abnormal behaviour 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 (dd/mm/yyyy)	Results of test/assessment

Name, Signature and Practice Stamp of the Specialist	Date

PART 4: PERSISTENT VEGETATIVE STAGE (APALLIC 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
4. Is there vertical eye movements and blinking?	☐ Yes ☐ No
5. Is there evidence of the following:	
a. Quadriplegia and inability to speak	☐ Yes ☐ No
b. Infarction of the ventral pons	☐ Yes ☐ No
c. EEG indicating that the patient is not unconscious	☐ Yes ☐ No
6. 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.	
7. 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.	
8. Is the patient's condition in a way related or due to AIDS or HIV related illness?	☐ Yes ☐ No
If Yes, please provide details.	
Name, Signature and Practice Stamp of the Specialist	Date

PART 5: IRREVERSIBLE APLASTIC ANAEMIA

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
4. Does the patient requires 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?	☐ Yes ☐ No
e. Hematopoietic stem cell transplantation?	☐ Yes ☐ No
f. Chemotherapy?	☐ Yes ☐ No
5. Please provide details of treatment administered, including date/period of treatment, name and address of attending doctors.	
6. 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, please provide more details to your answer.	

Name, Signature and Practice Stamp of the Specialist	Date

PART 6: SEVERE BACTERIAL MENINGITIS

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. Is the patient's condition in a way related or due to AIDS or HIV related illness?	☐ Yes ☐ No
If Yes, please provide details including date of diagnosis, name and address of the doctor who first made the diagnosis.	

Name, Signature and Practice Stamp of the Specialist	Date

PART 7: BLINDNESS (IRREVERSIBLE LOSS OF SIGHT)

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)

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 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, what 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

Name, Signature and Practice Stamp of the Specialist	Date

PART 8: COMA

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.).	
2. Was there any reaction or response to external stimuli or internal needs persisting continuously with the use of a life support system for at least 96 hours?	☐ Yes ☐ No
If Yes to the above, please support the basis with medical evidence.	
If No to 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?	☐ Yes ☐ 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?	☐ Yes ☐ 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?	☐ Yes ☐ 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 patient's condition resulting from alcohol, drug misuse or medically induced coma?	☐ Yes ☐ No
If Yes, please provide us with the details.	
Name, Signature and Practice Stamp of the Specialist	Date

PART 9: DEAFNESS (IRREVERSIBLE LOSS OF HEARING)

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**: Date of assessment: (dd/mm/yyyy) Hearing frequency in **right ear**: Date of assessment: (dd/mm/yyyy)		
4. Is there a total loss in all frequencies of hearing of 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 at least 40 decibels 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 at least 40 decibels?	(number of months)	
7. 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?		
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/mmm/yyyy)		
c. What is the best corrected hearing frequency in both ears?	Left ear	Right ear
Name, Signature and Practice Stamp of the Specialist	Date	

PART 10: END STAGE LIVER FAILURE

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?	(number of 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. What was the cause of the liver failure?	
10. Was the liver disease suffered by the patient secondary to alcohol abuse?	☐ Yes ☐ No
11. Was the liver disease suffered by the patient secondary to drug abuse?	☐ Yes ☐ No
If Yes to Q10 & Q11, please give details of the patient's habits in relation to alcohol assumption & drug abuse, including the amount of alcohol consumption per day and source of this information.	
12. What is the current condition of the patient and his/her prognosis?	

Name, Signature and Practice Stamp of the Specialist	Date

PART 11: END STAGE LUNG DISEASE

1. Please describe the patient's lung disease.	
2. Has the patient's lung disease reached end-stage?	☐ Yes ☐ No
3. Please state the exact date patient's lung disease has reached end-stage. (dd/mm/yyyy)	
4. Is the patient's FEV1 test results consistently less than 1 litre?	☐ Yes ☐ No
If No, please state patient's FEV1 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. If Yes, 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 (PaO2 ≤ 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 tick.	☐ Yes ☐ No
8. Please provide dates and details of all investigations carried out, including pulmonary function test, current FEV1 and vital capacity readings.	
Name, Signature and Practice Stamp of the Specialist	Date

PART 12: FULMINANT HEPATITIS

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.	
iii. 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.	
iv. Is there deepening jaundice?	☐ Yes ☐ No
If Yes, please give full details.	
v. Is there evidence of hepatic encephalopathy?	☐ Yes ☐ No
If Yes, please give full details, including dates, underlying causes, treatment and any complications.	
4. Was the patient's condition caused directly or indirectly by alcohol or drug abuse?	☐ Yes ☐ No
If Yes, please give details.	
5. What is patient's current condition and the prognosis?	

Name, Signature and Practice Stamp of the Specialist	Date

PART 13: OPEN CHEST HEART VALVE SURGERY

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 the date of the surgery. (dd/mm/yyyy)	
d. Was there the deployment of a permanent device or prosthesis by percutaneous intravascular techniques not involving thoracotomy?	☐ Yes ☐ No
e. Please describe the surgical procedure used to correct the valvular problem (i.e. open heart surgery, percutaneous intravascular balloon valvuloplasty with OR without thoracotomy etc.)	
f. Was the surgery procedure stated in Q6(d) above a form of an open-heart surgery?	☐ Yes ☐ No
i. If No, please state exact form of intervention.	

Name, Signature and Practice Stamp of the Specialist	Date

PART 14: HIV DUE TO BLOOD TRANSFUSION AND OCCUPATIONALLY ACQUIRED HIV	
1. Was the infection due to Blood transfusion?	☐ Yes ☐ No
2. Was the blood transfusion medically necessary or given as part of medical treatment?	☐ Yes ☐ No
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?	☐ Yes ☐ No
8. 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:	
9. 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 as definite source of the HIV infected fluids?	☐ Yes ☐ No
10. Was an HIV antibody test done after the incident of infection?	☐ Yes ☐ No
If Yes, what was the result?	

Name, Signature and Practice Stamp of the Specialist	Date

PART 15: 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 happen?	
c. Please describe the extent and severity of the bodily injuries/disability sustained, including exact site(s) of the body.	
If no, was it due to a self-inflicted injury?	☐ Yes ☐ No
4. Please describe and elaborate on the nature and severity of the patient's physical disability and limitation.	
5. Was there total and irreversible physical loss of all fingers including thumb of the same hand due to the above accident?	☐ Yes ☐ No
6. Please state date of last assessment in relation to patient's ability to perform activities of daily living? (dd/mm/yyyy)	
Name, Signature and Practice Stamp of the Specialist	Date

7. 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 tick if the patient can perform the listed activity?	Period of inability to perform	
		From (dd/mm/yyy)	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. What is the prognosis?
   a. If patient's condition is likely to improve, please state extent of improvement expected and estimated date of recovery.
   b. If the patient's condition is likely to deteriorate or remain static, please elaborate with reasons how you arrive at this opinion.

Name, Signature and Practice Stamp of the Specialist	Date

PART 16: IRREVERSIBLE LOSS OF SPEECH

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.	
3. Is the loss of speech as a result of injury to the vocal cords?	☐ Yes ☐ No
If Yes, please provide full and exact details, including date and the circumstance leading to the injury.	
4. Is the loss of speech as a result of disease to the vocal cords?	☐ Yes ☐ No
If Yes, please provide full exact details, including dates of diagnosis and treatments.	
5. If No to Q3 & Q4, what was the cause of the loss of speech?	
6. 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 reports (e.g. fiberoptic nasolaryngoscopy, etc.)	
7. 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?	
8. 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.	
9. Were there any associated 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.	

Name, Signature and Practice Stamp of the Specialist	Date

PART 17: MAJOR BURNS

1. What is the 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 burn 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 the date of incident resulting in major burns? (dd/mm/yyyy)	
b. Where and how did the accident happen resulting in major burns?	
c. Was there a police report made with regards 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 Third Degree (full thickness of skin) burns covering **at least 20%** of the surface of his/her body?	☐ Yes ☐ No
7. Has the patient undergone any skin graft to repair damaged skin?	☐ Yes ☐ No
a. IfYes, please state the date of skin grafting? (dd/mm/yyyy)	
8. Has the patient undergone any surgical debridement under general anaesthetic?	☐ Yes ☐ No
b. If Yes, please state the date of surgical debridement? (dd/mm/yyyy)	

9. Please state other alternative treatments patient has received, beside skin grafting and/or surgical debridement if any.

Name, Signature and Practice Stamp of the Specialist	Date

PART 18: MAJOR HEAD TRAUMA

1. What is the date of accident resulting in major head trauma? (dd/mm/yyyy)	
2. Where and how did the accident happen 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, suicide or attempted suicide, fits, etc.?	☐ Yes ☐ No
If Yes, please provide details. (e.g. result of blood alcohol concentration, alcohol, 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 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 deficit(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. Is the form of permanent neurological deficit due to a spinal cord injury?	☐ Yes ☐ No
If Yes to Q9, please provide details on the causes, where, when and how it happened?	
10. Was the head injury due to any other causes?	☐ Yes ☐ No
If Yes to Q10, please provide details on the causes, where, when and how it happened?	

Name, Signature and Practice Stamp of the Specialist	Date

PART 19: MAJOR ORGAN/BONE MARROW TRANSPLANTATION	
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 a recipient of a human bone marrow transplant? If Yes, please advise the following:	☐ 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 one marrow ablation?	☐ Yes ☐ No
5. 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 relevant organ?	☐ Yes ☐ No
d. What is the exact date the relevant organ has reached its end-stage? (dd/mm/yyyy)	

Name, Signature and Practice Stamp of the Specialist	Date

PART 20: MOTOR NEURONE DISEASE

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 attached 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.

5. Are the neurological deficits described in Q4 likely to be permanent?	☐ Yes ☐ No

Please provide more details to your answer.

Name, Signature and Practice Stamp of the Specialist	Date

PART 21: 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 at least 6 months?	☐ Yes ☐ No

If Yes to the above, please give details, including dates of each episode.

3. Was the neurological damage caused by Systemic Lupus Erythematosus (SLE) or Human Immunodeficiency Virus (HIV)?	☐ Yes ☐ No

If Yes, please provide details to your answer.

4. 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.

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

Name & Signature of the Specialist	Date

PART 22: MUSCULAR DYSTROPHY

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 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 tick if the patient can perform the listed activity?	Period of inability to perform	
		From (dd/mm/yyy)	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		

Name, Signature and Practice Stamp of the Specialist	Date

PART 23: PARALYSIS (IRREVERSIBLE LOSS OF USE OF LIMBS)

1. When was the date of onset? (dd/mm/yyyy)	

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

Please tick the specific limbs involved	Please describe the extent of loss of use	Please tick if the loss of use is 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

Name, Signature and Practice Stamp of the Specialist	Date

PART 24: IDIOPATHIC 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 is due to drug-induced causes?	☐ Yes ☐ No
3. Please confirm if the patient's diagnosis of Parkinson's Disease is due to toxic causes?	☐ Yes ☐ No
4. Please confirm if the patient's diagnosis of Parkinson's Disease is 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.

6. Is 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 tick if the patient can perform the listed activity?	Period of inability to perform	
		From (dd/mm/yyy)	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		

7. 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.

Name, Signature and Practice Stamp of the Specialist	Date

PART 25: 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.	
4. Was there paralysis of the respiratory muscles?	☐ Yes ☐ No
Please describe the impaired respiratory weakness resulting in 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
Name, Signature and Practice Stamp of the Specialist	Date

PART 26: PRIMARY PULMONARY HYPERTENSION

1. Is the pulmonary hypertension due to a primary cause?	☐ Yes ☐ No
2. Is the pulmonary hypertension due to a 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.	
11. Was there permanent physical impairment which fulfils the NYHA classification of cardiac impairment?	☐ Yes ☐ No
If Yes, please tick ✓ 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.	

Name, Signature and Practice Stamp of the Specialist	Date

PART 27: PROGRESSIVE SCLERODERMA

1. Please advise which form of scleroderma does the patient have?	
a. Localized scleroderma (linear scleroderma or morphea)	☐ Yes ☐ No
b. Eosinophilic fascitis	☐ 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. The heart	☐ Yes ☐ No
b. The lungs	☐ Yes ☐ No
c. The kidneys	☐ Yes ☐ No
Please provide more details to your answer above.	
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.).	

Name, Signature and Practice Stamp of the Specialist	Date

PART 28: OPEN CHEST SURGERY TO AORTA

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 the 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.	
5. Was there enlargement of the aorta?	☐ Yes ☐ No
If Yes, please state the diameter of the enlargement in millimetre.	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.	

Name, Signature and Practice Stamp of the Specialist	Date

PART 29: SYSTEMIC LUPUS ERYTHEMATOSUS WITH LUPUS NEPHRITIS

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-Sm (Smith IgG autoantibodies)	☐ Yes ☐ No
3. Is patient currently receiving systemic lupus immunosuppressive therapy due to involvement of multiple organs? Please tick ✓.	☐ Yes ☐ No
a. Please state the first treatment date of immunosuppressive therapy. (dd/mm/yyyy)	
b. Since the commencement date of immunosuppressive therapy, has the therapy lasted for a period of at least 6 months? Please tick ✓.	☐ Yes ☐ No
i. If No, what is the reason that it did not persist for a period of at least 6 months?	
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).	

Name, Signature and Practice Stamp of the Specialist	Date

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 tick ✓ 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 Nephrits

c. 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 involving any form of hematologic abnormalities?	☐ Yes ☐ No

If Yes to Q7, please provide details.

Name, Signature and Practice Stamp of the Specialist	Date

PART 30: SEVERE ENCEPHALITIS

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 hospitalization period. (dd/mm/yyyy)	From	To
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.

Name, Signature and Practice Stamp of the Specialist	Date