Name of Patient: NRIC / Passport No. of patient:

SECTION 2 MEDICAL SPECIALIST REPORT

TERMINAL ILLNESS

(To be completed by the Life Assured's attending 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
5. What is the diagnosis? Please describe the full and exact diagnosis of the condition causing patient to be terminally ill.						
6. What is/are the underlying cause(s)? Please also provide details if there are any other medical conditions associated with the cause of the terminal illness?						
7. Date of diagnosis.		DD		MM		YY
8. Date when patient / patient's next of kin was informed that the illness/condition was terminal.		DD		MM		YY
9. What are the assessments and/or objective investigations have been carried out and/or reviewed to support the patient current condition leading to terminal illness? Please provide details of all investigations/test performed and attach copies of results of any investigations performed and any other imaging studies, laboratory evidence etc. and other relevant hospital reports which confirmed the diagnosis						

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

Name of Patient: NRIC / Passport No. of patient:

10. Were you the doctor who first diagnosed the patient with this condition? Please circle.						Yes	No
11. If yes to Question 10, over what period do your records extend?	From (dd/mm/yy)				To (dd/mm/yy)		
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		YY	
c. When was the referral made for the patient to see you?							
d. What was the reason for referral to see you? Please attach a copy of the referral letter.							

PART II

1. What treatment is the patient currently receiving? For medications, please state the types and dosages of medication that the patient currently takes.
2. What was the patient's response to treatment, and how has this impacted on the patient's recovery and/or survival.
3. Has the patient been satisfactorily compliant (i.e. actively participate) with his/her treatment regime? If not, please provide details of suboptimal compliance, including reasons for this.

4. Has active treatment and therapy now been rejected in favor of relief of symptoms?	Yes	No
If Yes, please give details why this opinion or course of action is taken?		
5. What are the perpetuating factors (if any) that are currently delaying improvement of the condition/symptoms?		

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

Name of Patient: NRIC / Passport No. of patient:

6.	Please let us have your opinion on the following:						
	a. How long is the life expectancy of the patient?						months
	b. Is the patient's condition incurable that cannot be adequately treated and beyond any hope of recovery?					Yes	No
	c. Is the advent of death highly probable within 12 months from date of your most recent clinical / diagnostic examination?					Yes	No
	d. Please state date of your most recent clinical / diagnostic examination?		DD		MM		YY
	e. Based on your above answers, please explain and give supporting medical evidence to substantiate your opinion.						
7.	Is the patient currently an in-patient in a nursing home, hospital, hospice or other institution that provides constant care and medical attention?					Yes	No
	a. If Yes, since what date?		DD		MM		YY
8.	What is the prognosis of the terminal patient's current condition?						

Part III

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 the patient mentally incapacitated?	Yes	No
2.	Is the patient's terminal illness in the presence of 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

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

Name of Patient: NRIC / Passport No. of patient:

If Yes for any of the above in Q2, please provide the following details and also provide a copy of the investigation test result.

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

3. Has the patient previously suffered from the condition specified above or any related illnesses? If Yes, please provide the 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

4. Is there anything in the patient's medical history which would have increased the risk of the condition resulting in patient being terminally ill?	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 the 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 Specialist who filled up **Section 2**	Date
Practice Stamp of the 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.

Prudential Assurance Company Singapore (Pte) Limited (Reg. No.: 199002477Z)
Postal Address: Robinson Road P.O. Box 492, Singapore 900942
Tel: 1800 – 333 0 333 Fax: 6734 9555 Website: www.prudential.com.sg
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