

Attending Physician Statement – Deafness (Loss of Hearing)

Instruction to doctor: This patient is insured with us against the happening of certain contingent events associated with his health. A claim has been submitted in connection with Deafness (Loss of hearing). To enable us to assess the claim, please complete this report and return it directly to our company. For questions where date is applicable, please complete in the format of day/month/year.

To be completed and signed by the Attending Physician

I hereby certify that I personally examined the patient and my records and medical opinion are as follows:

1. Name of patient : _____ NRIC no. : _____

2. Are you the patient's regular medical attendant? Yes No
If yes, please provide details beginning with the first record in your clinic:

Date(s) consulted	Purpose & details of Consultation(s)	Diagnosis	Nature of treatment rendered, including type of tests and/or surgeries done

If no, do you know the name and address of the patient's regular medical attendant(s)? Yes No

If yes, please provide details:

Name of medical attendant	Address

3. Details of the consultation

3.1 Date you were first consulted for *hearing loss or hearing condition or for cochlea or auditory nerve injury (state the condition consulted).

3.2 State the symptoms presented, the medical history as presented by the patient and date when the symptoms first appeared.

Symptoms Presented at first consultation	Date symptoms first started

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3.3 Where is the source of this information about the patient’s condition? (Patient or referring doctor or others. If others, please specify)

3.4 In your opinion, how long do you think the symptoms first appeared prior to consulting you?

3.5 If the patient was referred to you OR if the patient had seen other doctor(s) before consulting you for this medical condition or its symptoms, please provide details:

Name of doctor(s) or hospital(s)	Address of doctor(s) or hospital(s)	Date consulted or date referred to you

(Please continue with your documentation on a blank page if there are more than 3 records and attached it with this report)

4. Details of the illness

4.1 Details of diagnosis:

Doctor’s diagnosis	
Diagnosis date	
Underlying cause (if any)	

4.2 Date of when patient was first informed of the diagnosis: _____

4.3 Name of doctor or hospital who first made the diagnosis:

4.4 Is the patient’s condition caused by an accident? Yes No
If yes, please provide details:

Date and time of accident	
Place of accident	
Description of how the accident happened	
Extent of injuries and any other external visible injuries	

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4.5 Please state the best corrected hearing frequency for both ears and provide supporting evidence such as audiogram.

Left ear	
Right ear	

4.6 Is the hearing loss permanent and irreversible? Yes No

4.7 is an additional question for cavernous sinus thrombosis

4.7 How was this diagnosis established? Please elaborate and include copy of diagnostic investigation report.

4.8 to 4.9 are additional questions for damage to cochlea or auditory nerve

4.8 Was the damage to the cochlea or auditory nerve permanent? Yes No

4.9 Was there total and permanent loss of hearing as a result of cochlea or auditory nerve injury? Yes No

4.10 Was the above diagnosis supported by radiological or laboratory evidence and confirmed by a specialist of the relevant field? Yes No

(a) If yes, please state mode of investigation done to establish the above diagnosis and attach copies of audiogram, sound-threshold tests results, operation reports and other diagnostic reports.

(b) If no, why and on what basis did you derive at such diagnosis?

4.11 Is the patient's condition or surgery performed in any way related or due to:

(a) AIDS or HIV related illness? Yes No

(b) Use of drug not prescribed by a registered medical practitioner or drug abuse? Yes No

(c) Alcohol abuse? Yes No

(d) Congenital anomaly or defect? Yes No

(e) Attempted suicide or self-inflicted injuries? Yes No

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If yes, please provide details and enclose a copy of the test result:

Diagnosis date	
Name and address of doctor who first diagnosed the patient with the above conditions	

5. Details of treatment and surgery

5.1 State the full details of all treatment provided (example medication, therapy).

Nature of treatment	Date(s) of treatment

5.2 Was there any surgery performed or going to be performed? Yes No
 If yes, please provide details and enclose a copy of the operation report:

Nature of surgery performed or going to be performed	Date(s) of surgery

5.3 Is there surgery available that could reinstate the patient’s hearing in either or both ears? Yes No

If yes, please state nature of surgery and tentative date of surgery under 5.2.

5.4 to 5.5 are additional questions for cavernous sinus thrombosis

5.4 Was craniotomy carried out to treat the cavernous sinus thrombosis? Yes No
 If yes, please state why craniotomy was found necessary

5.5 Is there other mode of treatment, other than craniotomy, which could have been used to treat the patient’s cavernous sinus thrombosis? Yes No
 If yes, please state the nature of other mode of treatment and why this treatment was not used.

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5.6 to 5.7 are additional questions for damage to cochlea or auditory nerve

5.6 Was surgical cochlea implant carried out to treat the cochlea or auditory nerve injury? Yes No

5.7 Is there other mode of treatment, other than surgical cochlea implant, which could have been used to treat the patient’s cochlea or auditory nerve injury? Yes No
If yes, please state the nature of other mode of treatment and why this treatment was not used.

5.8 Patient’s response to the treatment: _____

5.9 Was the patient referred to other doctor(s) for follow up or further management? Yes No
If yes, please state name and address of doctor(s) or hospital(s) and the reason(s) for referral.

5.10 Is the patient still on follow up treatment with you? Yes No
If yes, please state the follow up treatment plan.

6. Regarding the patient’s medical history

6.1 Has this patient *previously* suffered from the same condition or any related illnesses? Yes No
If yes, please provide details:

Date of when condition was first diagnosed	
Resulting diagnosis	
Name and address of doctor who attended to patient (if not attended to by you).	

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- 6.2 Is the patient suffering from or suffered from any other medical conditions? Yes No
 If yes, please provide details:

Name of doctor(s) or hospital(s) & Address	Diagnosis	Diagnosis date	Nature of treatment rendered, including type of tests and/or surgeries done

(Please continue with your documentation on a blank page if there are more than 4 records and attached it with this report)

- 6.3 Is there anything in the patient’s personal medical history which would have increased the risk of hearing loss or cavernous sinus thrombosis or cochlea/auditory nerve injury? Yes No

If yes, please provide full details, including the date of diagnosis, name and address of attending doctor and source of information.

- 6.4 Is there anything in the patient’s family history which would have increased the risk of hearing loss or cavernous sinus thrombosis or cochlea/auditory nerve injury? Yes No
 If yes, please provide full details, including relationship, nature of illness, diagnosis date and source of information.
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- 6.5 Please provide details of the patient’s habits in relation to cigarette smoking, including the duration of the smoking habit, number of cigarettes smoked per day and source of information.
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- 6.6 Please provide details of the patient’s habits in relation to alcohol consumption, including the amount of alcohol consumption per day and source of information.
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7. Please provide us with any other additional information that will enable us in assessing this claim.

Date

Name and signature of doctor

Address and official stamp

Qualifications