

Claim No. (For Office Use Only)									
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Confidential Medical Questionnaire – Brain, Nerve and Neurological Related Conditions

Instructions & Important Note:

- This form must be completed by the attending doctor (who is a registered Medical Practitioner qualified and licensed to practice western medicine and who is practicing within the scope of his / her licensing / training) at the claimant's expense.
- The attending doctor is required to tick (√) & complete the relevant part(s) below.
- If there is insufficient space, please use a separate sheet(s) of paper for your response.

Part A : Details of Patient (Person Covered) - This section is COMPULSORY to be completed for all Critical Illnesses

1. Name		2. Gender	[] Male [] Female
3. New NRIC Number		4. Old IC No. / Passport No / Birth Certificate No.	
5. Age		6. Certificate Number	

Important: Please enclose copies of all reports including X-rays, CT scans, any other imaging studies, laboratory evidence, surgery report, Histopathology examination (HPE), biopsy report, electroencephalogram (EEG) report, Mini Mental State Examination (MMSE) report, Glasgow Coma Scale report, electromyography (EMG), nerve conduction studies, CSF study etc. and any relevant hospital reports that are available.

Part B : Details of Diagnosis - Question 1 to 7 are COMPULSORY to be completed for all Critical Illnesses

1 a	Are you the patient's regular doctor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No						
b	If Yes, since when?	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td> </tr> </table>		D	D	M	M	Y	Y
D	D	M	M	Y	Y				
2 a	When were you first consulted for this illness?	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td> </tr> </table>		D	D	M	M	Y	Y
D	D	M	M	Y	Y				
b	What were the symptoms / complaints?	<hr/> <hr/>							
c	Date of onset of symptoms / complaints	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td> </tr> </table>		D	D	M	M	Y	Y
D	D	M	M	Y	Y				
Diagnosis									
3 a	Full and exact diagnosis	<hr/> <hr/>							
b	When was the illness FIRST diagnosed?	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	_____ am / pm
D	D	M	M	Y	Y				
c	When was the patient / patient's next of kin first informed of the diagnosis?	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	_____ am / pm
D	D	M	M	Y	Y				
d	What was / were the underlying cause(s)?	<hr/> <hr/>							
4 a	Details of investigations performed	<hr/> <hr/>							

b Details of treatment rendered

c Date of last consultation

D	D	M	M	Y	Y
---	---	---	---	---	---

d The patient's condition as at last consultation date

Details of hospitalisation

5 a Name of Hospital

b Date and time of admission

D	D	M	M	Y	Y
---	---	---	---	---	---

_____ am / pm

c Date and time of discharge

D	D	M	M	Y	Y
---	---	---	---	---	---

_____ am / pm

d Name of surgery performed

e Date of surgery

D	D	M	M	Y	Y
---	---	---	---	---	---

f Was the patient admitted to Intensive Care Unit (ICU)?

Yes No

If "Yes", how many days: _____

g Was the patient placed on life support measures?

Yes No

If "Yes", how many days: _____

Which of the following essential life support was used?

Invasive ventilator-assisted breathing through tracheal intubation
 Extracorporeal membrane oxygenation (ECMO)
 Intra-aortic balloon pump (IABP)
 Hemofiltration, haemodialysis, peritoneal dialysis or total parenteral nutrition
 Others, please specify: _____

6 Is the current diagnosis related to:

Congenital
 Hereditary
 Due to Alcohol / Drugs
 Self-inflicted Injury
 Mental / Emotional / Sleeping Disorder
 Pregnancy / Childbirth / Miscarriage
 Acquired Immune Deficiency Syndrome (AIDS)
 Human Immuno-deficiency Virus (HIV) Infection
 Traumatic Injury
 None of the above

7 To your knowledge, has the patient suffered from any of the following illness / condition?

- a Hyperlipidemia
- b Hypertension
- c Diabetes
- d Any Other Illness or Disability, please specify.

Yes	No	Date of Onset	Name of Doctor / Clinic / Hospital
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		

Part C : Details of Critical Illness - This section is applicable to SPECIFIC CRITICAL ILLNESS only

8 **Alzheimer's Disease / Severe Dementia / Irreversible Organic Degenerative Brain Disorders**

a Type of Disease

Alzheimer's Disease
 Moderately Severe Alzheimer's Disease
 Dementia
 Severe Dementia
 Irreversible Organic Degenerative Brain Disorders
 Others, please specify: _____

b Any evidence of deterioration or loss of intellectual capacity or cognitive function? Yes No

c Any abnormal behaviour resulting in significant reduction in mental and social functioning? Yes No

d Was there any permanent clinical loss of ability to do all of the following?
(i) Remember Yes No
(ii) Reason Yes No
(iii) Perceive, understand, express and give effect to ideas Yes No

e Please provide the details of examinations performed:
(i) Date of assessment performed

D	D	M	M	Y	Y
---	---	---	---	---	---

(ii) Mini Mental State Examination (MMSE) _____ out of 30 points
(iii) Any other equivalent tests, please specify. _____

f Does the patient require continuous supervision? Yes No
If "Yes", since when: _____ (DD/MM/YYYY)
Please give details: _____

g Was the deterioration or loss of intellectual capacity or abnormal behaviour arises from the following?
(i) Neurosis Yes No
(ii) Psychiatric illness Yes No
(iii) Drug or alcohol related brain damage Yes No
(iv) Head injury related brain damage Yes No
If "Yes", please give details: _____

h Was the condition medically documented for at least three months since diagnosis date? Yes No
If "Yes", provide details / basis of evaluation (last evaluated) and the progression of patient's Alzheimer's Disease / dementia condition since first seen.

9 **Apallic Syndrome**

a Was there any presence of universal necrosis of the brain cortex with the brainstem remaining intact? Yes No

b Please describe the neurological sequelae

c Was the condition persisted for at least one month since diagnosis date? Yes No
If "Yes", please state the duration for which it has persisted and supported with a copy(ies) of medical reports. (e.g. EEG)

10 **Bacterial Meningitis / Encephalitis**

a What was the causative agent of the infection?
 Bacterial
 Virus
 Others, please specify: _____

- b Was the disease causing inflammation of the membranes of the brain or spinal cord? Yes No
- c Was there any significant neurological deficit? Yes No
If "Yes", please give details: _____
- d Is the neurological deficit permanent? Yes No
- e Was the patient HIV positive? Yes No
- f Was the disease a result of HIV infection? Yes No
- g For bacterial meningitis, was there a presence of bacterial infection in the cerebrospinal fluid by lumbar puncture? Yes No
- h Did the patient require 72 hours of hospitalisation? Yes No

11 **Brain (Aneurysm) Surgery / Cerebral Shunt Insertion**

- a Did the patient undergo surgery of the brain? Yes No
- b Which of the following surgical procedure performed?
 Craniotomy
 Burr Hole
 Transsphenoidal
 Endoscopic Assisted Procedures
 Endovascular Repair or Procedures
 Other Minimal Invasive Procedures
 Other procedure, please specify: _____
- c Date of surgery

D	D	M	M	Y	Y
---	---	---	---	---	---
- d Reason for surgery _____
- e Was the surgery performed due to injuries sustained during an accident? Yes No
- f Was a cerebral shunt implanted during the surgery? Yes No
If "Yes", please give details: _____

12 **Benign Brain Tumour**

- a Where was the location of the tumour? _____
- b What is the nature of the tumour?
 Benign
 Malignant
Please state the extent of the tumour lesion and stage.
(Note: Please also state the staging system used.)

- c Has it caused damage to the brain? Yes No
If "Yes", please give details: _____
- d Was the presence of the underlying tumour confirmed by CT scan, MRI or other imaging studies? Yes No
If "Yes", please enclose copies of all investigation performed, e.g. biopsy results, cytology reports, CT scan, MR imaging etc.

e Was the tumour life threatening?

Yes No

If "Yes", please give details: _____

f Were there characteristic signs of intra-cranial pressure?

Yes No

If "Yes", were the below symptoms / signs present?

Papilloedema	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Mental symptoms	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Seizures	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Sensory impairment	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Other, please specify: _____

g Was the neurological deficit permanent with persisting clinical symptoms?

Yes No

If "Yes", please give details: _____

h Has the tumour been surgically removed?

Total removal
 Partial removal
 No removal

i Is the diagnosis falling within any of the following conditions?

Cysts
 Granulomas
 Malformations in or of the arteries or veins of the brain
 Haematomas
 Tumours in the pituitary gland
 Tumours in the spine
 Tumours of the acoustic nerve

13 **Coma**

a Was there any reaction or response to external stimuli or internal needs?

Yes No

If "No", how long was the patient in a state of coma, with no response to external stimuli or internal needs?

_____ hours / _____ days since _____ (DD/MM/YYYY)

b Was the patient placed on life support measures?

Yes No

If "Yes", for how long?

_____ hours / _____ days

c Are there any permanent neurological deficits of more than 30 days?

Yes No

If "Yes", please give details: _____

d What is the extent of coma under the Glasgow Coma Scale?

e Is the coma resulting from any of the following?

Alcohol
 Drug abuse / misuse
 Self-inflicted injury
 Medically induced
 None of the above

14 **Major Head Trauma**

a Date of injury

D	D	M	M	Y	Y
---	---	---	---	---	---

b Details of circumstance leading to injury

c What is the exact location and extent of the head injury?

d Was any surgery performed?

Yes No

If "Yes", please give details of surgical procedure:

e Details of functional impairment and how long the impairment has lasted from the date of trauma or injury

Impairment	Start Date (DD/MM/YYYY)	Last Assessment Date (DD/MM/YYYY)

f Is such an impairment expected to be permanent?

Yes No

g Is the patient permanently bedridden as a result of the head trauma?

Yes No

15 **Motor Neuron Disease**

a Type of Motor Neuron Disease

Spinal muscular atrophy
 Progressive bulbar palsy
 Amyotrophic lateral sclerosis
 Primary lateral sclerosis
 Others, please specify the exact diagnosis: _____

b Please describe the neurological sequelae

c Are these sequelae permanent?

Yes No

d Is the patient currently:

Ambulatory
 Confined at home
 Confined at hospital
 Confined at bed
 Subject to some other restriction in movement or lifestyle?
If so, please give details: _____

16 **Multiple Sclerosis**

a Were there any symptoms referable to tracts (white matter) involving the optic nerves, brain stem and spinal cord, producing well-defined neurological deficits?

Yes No

If "Yes", please give details: _____

b Was there any evidence of multiplicity or discrete lesions on imaging studies?

Yes No

If "Yes", please enclose copies of reports.

c Were the multiple neurological deficits resulting in demyelination and impairment of motor and sensory functions occurring over a continuous period of at least six (6) months?

Yes No

If "Yes", since when: _____ (DD/MM/YYYY)

d Was there a history of exacerbations and remissions of the said symptoms or neurological deficits?

Yes No

If "Yes", please indicate number of exacerbations since diagnosis: _____

e Was the neurological damage caused by the following?

(i) Systemic Lupus Erythematosus

(ii) Human Immuno-deficiency Virus (HIV) Infection

 Yes
 Yes No
 No

If "Yes", please provide the diagnosis date: _____ (DD/MM/YYYY)

f Was the disease a result of a single nerve affections?

 Yes No

g Details of investigations performed

Investigation / Test	Finding / Test Result

17

Muscular Dystrophy

a Type of Muscular Dystrophy

 Duchenne's
 Becker
 Limb Girdle Muscular
 Family history of other affected individuals
 Congenital
 Others, please specify: _____

b Which are the central / peripheral nerves involved?

c Was there any evidence of absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction?

 Yes No

If "Yes", please describe findings: _____

d Was the diagnosis confirmed by the following?

(i) An electromyogram

(ii) Muscle biopsy

(iii) CPK estimations

 Yes
 Yes
 Yes No
 No
 No

If "Yes", please enclose copies of reports.

e Has the condition medically documented for at least three months since diagnosis?

 Yes No

f Is the patient currently:

 Ambulatory
 Confined at home
 Confined at hospital
 Confined at bed
 Subject to some other restriction in movement or lifestyle?

If so, please give details: _____

18

Paralysis / Poliomyelitis

a Is there paralysis?

 Yes No

b What is the underlying cause of paralysis?

 Accident
 Sickness
 Self-inflicted injury
 Partial paralysis
 Temporary post-viral paralysis
 Psychological causes
 Guillain-Barre syndrome
 Others, please specify: _____

c Is the loss of use of the involved limbs considered total, permanent and irreversible?

Yes No

If "Yes", since when: _____ (DD/MM/YYYY)

d For Poliomyelitis, was there evidence of infection by the poliovirus resulting in impairment of motor function or respiratory weakness?

Yes No

19 **Parkinson's Disease**

a Can the patient's condition be controlled with medication?

Yes No

b Are there signs of progressive impairment?

Yes No

c What is the underlying cause of the disease?

Idiopathic
 Drug-induced
 Toxins
 Others, please specify: _____

d Is the patient currently:

Ambulatory
 Confined at home
 Confined at hospital
 Confined at bed
 Subject to some other restriction in movement or lifestyle?

If so, please give details: _____

20 **Stroke**

a Please describe the initial episode:

(i) Date of the episode

D	D	M	M	Y	Y
---	---	---	---	---	---

(ii) Nature of the episode

(iii) Duration of the acute symptoms

b What is the underlying cause of the disease?

Infarction of brain tissue
 Cerebral haemorrhage
 Embolization from an extracranial source
 Subarachnoid haemorrhage
 Others, please specify: _____

c Were there any changes seen in a CT scan or MRI?

Yes No

If "Yes", please enclose copies of reports.

d Please describe the neurological sequelae

e Are these sequelae permanent?

Yes No

f Is the condition related to the following?

Transient ischemic attack
 Any reversible ischemic neurological deficit
 Vertebrobasilar ischemia
 Cerebral symptoms due to migraine
 Cerebral injury resulting from trauma or hypoxia
 Vascular disease affecting the eye or optic nerve or vestibular functions

Part D : Neurological Examination Report – This section is COMPULSORY to be completed based on LATEST / CURRENT assessment

1 a Date when the patient's neurological impairments were first noted / onset

D	D	M	M	Y	Y
---	---	---	---	---	---

b Date of latest / current assessment

D	D	M	M	Y	Y
---	---	---	---	---	---

Note: Question 2 to 8 are compulsory to be completed based on the patient's latest / current condition.

2 Vision
(Visual Acuity Both Eye)

	Right	Left
Normal		
Impaired		
Scores based on Metric Acuity		

Remarks: _____

3 Hearing
(For ENT Specialist Opinion, Audiometry)

	Right	Left
Normal		
Impaired		
Scores based on Speech Reception Threshold (dB)		

Remarks: _____

4 Function of speech

<input type="checkbox"/>	Clear and understandable
<input type="checkbox"/>	Slurred
<input type="checkbox"/>	Unable to speak
<input type="checkbox"/>	Others, please specify: _____

5 Cognitive function

<input type="checkbox"/>	Normal
<input type="checkbox"/>	Poor comprehension
<input type="checkbox"/>	Difficult with logic and reasoning
<input type="checkbox"/>	Memory loss
<input type="checkbox"/>	Others, please specify: _____

6 General Inspection:

a Is there any abnormal movement?
(Please explain in detail, if any)

b Is there any muscle wasting?
(Please explain in detail, if any)

7 Examination of Limbs:

Please indicate the muscle power of each joint in the boxes provided.

(Lowest score: 0; Highest score: 5)

a Upper Limbs

	Right	Left
Shoulder	/ 5	/ 5
Elbow	/ 5	/ 5
Wrist	/ 5	/ 5
Grip	/ 5	/ 5

b Lower Limbs

	Right	Left
Hip	/ 5	/ 5
Knee	/ 5	/ 5
Ankle	/ 5	/ 5

Remarks: _____

8 Assessment of Activities of Daily Living:

NO LIMITATION LIMITED BUT CAPABLE COMPLETELY INCAPABLE

<p>a Transfer (Getting in and out of a chair without requiring physical assistance)</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>b Mobility (The ability to move from room to room without requiring any physical assistance)</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>c Continence (The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene)</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>d Dressing (Putting on and taking off all necessary items of clothing without requiring assistance of another person)</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>e Bathing (The ability to wash in the bath or shower (including getting in and out of the bath or shower) or wash by any other names)</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>f Eating (All tasks of getting food into the body, once it has been prepared)</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9 Is the patient currently undergoing any form of rehabilitation?

Yes No

If "Yes", please provide the details of rehabilitation:

10 What is the prognosis of the patient's neurological impairments?
(You may tick more than one box.)

- Recovered
- Stable and improving
- No change
- Progressively worsening
- Permanent

Remarks: _____

11 Is there continuous improvement in the patient's condition?

Yes No

Remarks: _____

Part E : Patient's Medical Information - This section is COMPULSORY to be completed for all Critical Illnesses

1. Please provide the name and address of all doctors, specialists, or hospitals to which the patient has been referred or attended for this condition.

Consultation date(s)	Name of Doctor	Name and Address of Clinic / Hospital

2. (a) Has the patient previously suffered from this disease or any related illness? Yes No

(b) If Yes, please state the dates of consultations, diagnosis, name of doctor, name of clinic / hospital and the treatments / medications given.

Consultation Date(s)	Diagnosis	Name of Doctor	Name of Clinic / Hospital	Treatment / Medication(s) Given

3. In your opinion, is there any further information that will assist us in assessing the claim. If Yes, please furnish such information below.

I hereby certify that I have personally examined and treated the patient for the above injuries / illness. I hereby declare that all the answers and statements are complete and true to the best of my knowledge, belief and that I have withheld no material fact from the Company. I also hereby certify that the above information is correct as per records from the hospital / clinic.

Signature of Attending Physician	Name & Qualification of Attending Physician	Official Stamp of Hospital								
Date	Email Address	Telephone No								
<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y		
D	D	M	M	Y	Y	Y	Y			



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