LONG TERM GOLDENCARE
DOCTOR'S STATEMENT

Great Eastern
Life is Great
A member of the OCBC Group

* Please delete where appropriate

For Official Use

G E L S –

O A C S –

Name of Life Assured:

NRIC/ Passport No.:

Date of Birth (dd/mm/yyyy):

Gender: M / F *

1. MEDICAL HISTORY

Record the Life Assured's five (5) years medical history. List past and current health problems, diagnosis, date of onset and current status (including whether stable or unstable) in chronology.

Health Problems	Diagnosis	Date of Onset	Status
Circulatory			
Respiratory			
Neurological			

Date

Signature of Doctor

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
The Overseas Assurance Corporation Limited (Reg No. 1920 00011W)
Claims Department
1 Pickering Street #13-01 Great Eastern Centre Singapore 048659
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
Email: LifePAClaims-SG@greateasternlife.com Website: greateasternlife.com

CCLM
CCLMDOCLTC

Jan 2015

Health Problems	Diagnosis	Date of Onset	Status
Gastrointestinal			
Musculoskeletal			
Sensory			
Genitourinary			

Date

Signature of Doctor

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Jan 2015

Health Problems	Diagnosis	Date of Onset	Status
Endocrine			
Psychiatric			
Others			

2. CURRENT MEDICATION PROFILE

Record the Life Assured's prescribed and over-the-counter medications below.

Medication	Dosage/ Frequency	Start Date	Reason	Prescribing Physician

Date

Signature of Doctor

3. ACTIVITIES OF DAILY LIVING ("ADL") FUNCTION

(a) Please tick as applicable in relation to the Life Assured's ADL ability.

Notes:

"**NO assistance**" means the Life Assured requires no assistance to perform the ADL.

"**SOME assistance**" means the Life Assured requires some assistance of another person up to 74% of the time to perform the ADL.

"**SUBSTANTIAL assistance**" means the Life Assured requires another person at least 75% of the time to perform the ADL.

"**FULL assistance**" means the Life Assured is not able to perform the ADL even with the aid of the special equipment, and always requiring the physical help of another person throughout the entire ADL.

(i) **Washing/ Bathing**
(ability to wash in bath or shower or by other means to maintain personal cleanliness.)

☐ NO assistance ☐ SOME assistance ☐ SUBSTANTIAL assistance ☐ FULL assistance

Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary).

_____

_____

(ii) **Dressing**
(ability to dress and undress and put on and take off any medical appliances usually worn.)

☐ NO assistance ☐ SOME assistance ☐ SUBSTANTIAL assistance ☐ FULL assistance

Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary).

_____

_____

(iii) **Bladder/ Bowel Continence**
(ability to manage bowel and bladder function with or without the use of catheters, incontinence pads or other artificial aids to maintain personal hygiene.)

☐ NO assistance ☐ SOME assistance ☐ SUBSTANTIAL assistance ☐ FULL assistance

Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary).

_____

_____

(iv) **Mobility**
(ability to move indoors from room to room on level surfaces.)

☐ NO assistance ☐ SOME assistance ☐ SUBSTANTIAL assistance ☐ FULL assistance

Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary).

_____

_____

_____ _____

Date Signature of Doctor

(v) **Transferring**
(ability to move from a bed to an upright chair or wheelchair and vice versa.)

☐ NO assistance ☐ SOME assistance ☐ SUBSTANTIAL assistance ☐ FULL assistance

Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary).

_____

_____

(vi) **Feeding**
(ability to ingest food when it is made available.)

☐ NO assistance ☐ SOME assistance ☐ SUBSTANTIAL assistance ☐ FULL assistance

Comment (if assistance is required, please include date (dd/mm/yy) when such assistance became necessary).

_____

_____

(b) Please state the basis of your opinion of the Life Assured's ADL ability (e.g. face to face assessment, report from patient, report from relative, etc).

_____

_____

(c) What tests did you use to establish the Life Assured's function for each of the ADLs (standardised functional assessments, observation of patient performing ADL-specific tasks, etc)?

_____

_____

(d) When did you last see the Life Assured and for how long?

_____

_____

(e) In what environment did you last see the Life Assured (e.g. home, hospital, nursing home, relative's home, etc)?

_____

_____

_____ _____

Date Signature of Doctor

4. MENTAL STATUS

(a) Please describe the Life Assured's mental and cognitive abilities.

_____

_____

(b) State date when such cognitive ability commenced and whether it is continuous or intermittent.

_____

_____

(c) What is the Life Assured's Mini-Mental State Examination score and date(s) of such examination?

_____

_____

(d) What is the diagnosis of the Life Assured's condition leading to such cognitive ability? Please also provide date of diagnosis.

_____

_____

(e) Is the Life Assured mentally incapacitated in accordance to the Mental Capacity Act (Chapter 177A of Singapore)? YES / NO*

(f) Please provide details if the Life Assured is depressed or has psychiatric illness.

_____

_____

(g) What is the prognosis of the Life Assured's condition?

☐ Poor

☐ Guarded

☐ Fair

☐ Good

☐ Excellent

Comments: _____

_____ _____

Date Signature of Doctor

(h) What is the prognosis based on recent test results, recent assessment, specialist opinion, etc?

(i) Describe the Life Assured's need for continual care or supervision.

5. PLAN OF TREATMENT

Type of Service Required	Description of Service Required	No. of Hours Per Day	
Skilled nursing			
Companion			
Others			

6. Is the Life Assured's condition due to any of the following? YES / NO*

If "YES", please tick in the ☐ and provide details:

Duration (State Date)

☐ Self-inflicted injury.

☐ Suicide or attempted suicide.

☐ Alcoholism or drug addiction.

☐ AIDS or any illness related to the Human Immunodeficiency Virus.

Details: _____

7. Please provide any further information which in your opinion would be useful in the assessment of this Life Assured's claim.

Date

Signature & Official Stamp of Doctor

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