LONG TERM CARE BENEFIT ASSESSMENT REPORT

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

SECTION 1 – PERSONAL DETAILS

DETAILS OF POLICY

Prudential Policy Number(s):

DETAILS OF LIFE ASSURED (PATIENT)

Full Name					
NRIC / Passport No.		Date of birth		Gender	
Address					
Contact No.		Email address			

SECTION 2 – MEDICAL DETAILS

2.1. How long have you been the patient's medical attendant?

2.2. Date of the earliest records you hold for this patient (DD/MM/YYYY).

2.3. When did you last see the patient (DD/MM/YYYY)?

2.4. In order for us to understand what active medical problems your patient is experiencing please provide details below.

Nature of currently active medical conditions (diagnosis if applicable)	**Date first consulted (DD/MM/YYYY)**	**Treatment/Medication**

Signature & Practice Stamp of the Medical Specialist	Date

a. Please describe the symptoms presented by patient in relation to the information provided for Question 2.4.

b. Are the conditions considered terminal?	Yes	No

If yes, what is the estimated life expectancy?

☐ 0-6 months
☐ 6-12 months
☐ 12-18 months
☐ More than 18 months

c. Is there any likelihood that your patient's condition(s) could improve?	Yes	No

If yes, what time scale would you put on this?

d. Has your patient been referred to other specialist(s) for the condition(s)?	Yes	No

If yes, please give name and address of the specialist(s).
Kindly enclose copies of any correspondence or notes.

2.5. Is your patient currently suffering from any psychological symptoms such as anxiety or depression?	Yes	No

If yes, please provide details of his/her condition and treatment.

2.6. Are the psychological symptoms affecting your patient's ability or motivation to manage the activities of daily living?	Yes	No

Please give your comments.

2.7. MEDICAL HISTORY: Apart from the currently active medical conditions detailed in Question 2.4 in this form, please provide information on any significant illness or accident which your patient has suffered **in the past**.

Nature of illness/injury suffered <u>in the past</u>	**Date of diagnosis/accident (DD/MM/YYYY)**	**Treatment/Medication**	**Approximate Duration**

Signature & Practice Stamp of the Medical Specialist

Date

SECTION 3 – CARE NEEDS

3.1 ACTIVITIES OF DAILY LIVING

Please use the Rating Guide to indicate the level of personal assistance your patient requires for the following activities numbered 3.1.1 to 3.1.7.

RATING GUIDE	
Score 1	Able without assistance, i.e. no help is needed
Score 2	Occasional help, i.e. need help less than 50% of the time
Score 3	More often than not, i.e. need help about 50% - 75% of the time
Score 4	Most of the time, i.e. need help 75% - 90% of the time
Score 5	Almost always/always, i.e. need help all the time or unable to perform

Activity	Score (refer to Rating Guide)	Date from which help was required (DD/MM/YYYY)	Equipment need	Care need i.e. is assistance required from another person
3.1.1 Getting in and out of a chair				
3.1.2 The ability to move indoor from room to room on level surfaces				
3.1.3 The ability to voluntarily control bowel and bladder functions such as to maintain a satisfactory level of personal hygiene				
3.1.4 Putting on and taking off all necessary items of clothing				
3.1.5 Transferring from bed to chair and vice versa				
3.1.6 The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means				
3.1.7 All tasks of getting food into the body once if has been prepared and made available				

Signature & Practice Stamp of the Medical Specialist	Date

3.2 SUPERVISION RESULTING FROM MENTAL IMPAIRMENT

The information you will provide us in this section will assist us in understanding the level of supervision your patient needs in order to maintain his/her safety and wellbeing.

If this patient has been assessed and given a diagnosis by an Old Age Psychiatrist or similar professional, please enclose a copy of his/her report or relevant correspondence. This may avoid the need for this patient to undergo an independent assessment for the purpose of the Long Term Care Benefit claim

3.2.1	How long have you been the patient's medical attendant?		
3.2.2	What activities do the patient require supervision or care with as a result of mental impairment?		
3.2.3	Has the patient been formally assessed on his/her cognitive state?	Yes	No
	If yes, please provide the results of any test or investigation.		

3.2.4 For the following activities, please put a tick in the box alongside the statements that best describe your patient's ability to manage these activities.

a. Can the patient use the telephone?

☐ Without help, including looking up numbers and dialling

☐ With some help e.g. can answer phone or dial operator in an emergency but needs a special phone or help in getting the number or dialling

☐ Completely unable to use the telephone

☐ Not known

b. Can the patient get to places out of walking distance?

☐ Without help e.g. can travel alone on buses, taxis or drive own car

☐ With some help e.g. needs someone to help him/her or to go with him/her when travelling

☐ Unable to travel unless emergency arrangements are made for a special vehicle like an ambulance.

☐ Not known

c. Can the patient go shopping, assuming he/she has transportation?

☐ Without help e.g. can take care of all shopping needs

☐ With some help e.g. needs someone to go with him/her on all shopping trips

☐ Completely unable to do any shopping

☐ Not known

Signature & Practice Stamp of the Medical Specialist	Date

d. Can the patient prepare his/her own meals?

☐ Without help e.g. can plan and cook meals independently

☐ With some help e.g. can prepare some things but unable to cook full meals

☐ Completely unable to prepare any meals

☐ Not known

e. Can the patient prepare and take his/her own medicines?

☐ Without help e.g. in the right doses at the right time

☐ With some help e.g. able to take medicines if someone prepares it for him/her and/or reminds him/her to take it

☐ Unable to take it on his/her own

☐ Not known

f. Can the patient handle his/her own money?

☐ Without help e.g. can write cheques and pay bills etc

☐ With some help e.g. manage day to day expenses but needs help with managing cheque book and paying bills

☐ Completely unable to handle money

☐ Not known

SECTION 4 – ADDITIONAL INFORMATION

4.1 Is there other information in your opinion may assist us in considering the Long Term Care claim?

Signature & Practice Stamp of the Medical Specialist	Date