



Claim No.: \_\_\_\_\_

## MEDICAL ATTENDANT'S REPORT ON DREAD DISEASE CLAIM

This report is to be completed by a registered medical practitioner at the own expense of Participant / Claimant.

In order for a claim under this Takaful Certificate condition to be paid, the following definition must be satisfied:

### BENIGN BRAIN TUMOUR

A non-cancerous tumour in the brain. Cysts, granulomas, malformations in, or of, the arteries or veins of the brain, haematomas and tumours in the pituitary gland or spine are not covered.

1. a) Name of Participant. b) I/C No. c) Date of Birth. d) Present Occupation. (If more than one, please state all) e) Takaful Certificate No.	a) b) c) d) e)
2. Please describe the exact details of your patient's present condition.	
3. a) When did your patient first consult you for this condition? b) Symptoms presented at that time. c) Date of symptoms first appeared.	a) b) c)
4. When did your patient first become aware of this condition?	

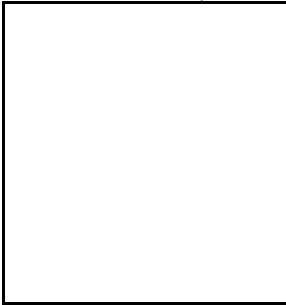
<p>5. Had your patient suffered any previous episodes of this condition or any other conditions leading to it or relating to it? If so, please give details.</p>	
<p>6. Are you aware of any members of your patient's close family who have suffered from this or any similar conditions?</p>	
<p>7. a) Was your patient referred to you? If so, please give name and address of doctor concerned.</p> <p>b) Name and address of doctor(s) who attended to your patient prior to seeing you.</p> <p>c) Name and address of doctor(s) concurrently treating your patient with you for this condition.</p> <p>d) Was your patient referred to any other doctor(s) by yourself? Please give name and address of the doctor(s).</p>	<p>a)</p> <p>b)</p> <p>c)</p> <p>d)</p>

<p>8. Please complete the section below relating to your patient's condition.</p> <p>a) Please indicate the exact location of the tumour in the brain.</p> <p>b) Please confirm the diagnosis of brain tumour and give details of the type of tumour.</p> <p>c) Please give histology and staging of tumour.</p> <p>d) Please give an exact description of the site of the tumour.</p> <p>e) Please describe the treatment undergone or anticipated.</p> <p>f) Hospital and name of surgeon who operated your patient.</p>	<p>a)</p> <p>b)</p> <p>c)</p> <p>d)</p> <p>e)</p> <p>f)</p>
<p>9. a) Please state date of diagnosis.</p> <p>b) Name and address of doctor who established the diagnosis.</p> <p>c) Was your patient informed of the diagnosis? If so, when and by whom.</p>	<p>a)</p> <p>b)</p> <p>c)</p>
<p>10. Have any other investigative tests or procedures been performed? If so, please give details.</p>	

<p>11. Please give details of your patient's smoking habits, both past and present.</p> <p>a) Does the patient smoke?</p> <p>    i) If "Yes", how many sticks does the patient smoke in a day?</p> <p>    ii) What is the exact duration?</p> <p>b) If "No", is the patient a non-smoker?</p> <p>c) If he was a smoker in the past, then when did the patient stop smoking?</p>	<p>a)</p> <p>i)</p> <p>ii)</p> <p>b)</p> <p>c)</p>																				
<p>12. Has the patient ever been diagnosed / suffered from any of the following:</p> <p>a) Hypertension.</p> <p>b) Diabetes Mellitus.</p> <p>c) Cardiovascular Disease.</p> <p>d) Other Illness(es) / Injuries.</p> <p>If so, please provide diagnosis, date of diagnosis / onset, names and addresses of all doctors consulted and dates of consultation.</p>	<table border="1"> <thead> <tr> <th data-bbox="799 696 911 725">Diagnosis</th> <th data-bbox="940 696 1070 792">Date of Diagnosis / Onset</th> <th data-bbox="1098 696 1235 826">Name and Address of Doctor(s) Consulted</th> <th data-bbox="1302 696 1422 792">Dates of Treatment Consulted</th> </tr> </thead> <tbody> <tr> <td data-bbox="799 837 826 866">a)</td> <td></td> <td></td> <td></td> </tr> <tr> <td data-bbox="799 1001 826 1030">b)</td> <td></td> <td></td> <td></td> </tr> <tr> <td data-bbox="799 1164 826 1193">c)</td> <td></td> <td></td> <td></td> </tr> <tr> <td data-bbox="799 1328 826 1357">d)</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Diagnosis	Date of Diagnosis / Onset	Name and Address of Doctor(s) Consulted	Dates of Treatment Consulted	a)				b)				c)				d)			
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<p>13. Please give any other information which you feel would be helpful in the assessment of your patient's claim.</p>																					

We would be most grateful if you could send copies of any specialist or hospital reports, together with any tests, readings, or similar evidence to support the validity of your patient's claim.

Official Stamp:



Signature: \_\_\_\_\_

Name (in block capitals please): \_\_\_\_\_

Qualification: \_\_\_\_\_

Date: \_\_\_\_\_

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Checked and Verified By: \_\_\_\_\_ Date: \_\_\_\_\_ Branch: \_\_\_\_\_  
(Name of Staff)