هوڠ ليوڠ م. س. أ. ج. تكافل

HongLeong MSIG Takaful

Claim No.: _____

MEDICAL ATTENDANT'S REPORT ON DREAD DISEASE CLAIM

This report is to be completed by the 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:

SYSTEMIC LUPUS ERYTHEMATOSUS (SLE) WITH LUPUS NEPHRITIS

Refers to a multisystem, multifactorial, autoimmune disorder, which affects mostly females in their childbearing years and is characterized by the development of autoantibodies, directed against various self-antigens.

In respect of this contract, SLE will be restricted to those forms of systemic lupus erythematosus, which involve the kidneys (Type III to Type IV Lupus Nephritis, established by renal biopsy). Other forms, discoid lupus, and those forms with only hematological and joint involvement will be specifically excluded.

WHO Lupus Classification:
Class I (minimal change) – Negative, normal urine.
Class II (Mesangial) – Moderate proteinuria, active sediment.
Class III (Focal Segmental) – Proteinuria, active sediment.
Class IV (Diffuse) – Acute nephritis with active sediment and /or nephritic syndrome.
Class V (Membranous) – Nephrotic Syndrome or severe proteinuria.

1. a) Name of Participant.	a)
b) I/C No.	b) Old: New:
c) Date of Birth.	c)
d) Present Occupation. (If more than one, please state all)	d)
e) Takaful Certificate No.	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?	
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.	
6. Are you aware of any members of your patient's close family who have suffered from this or any similar conditions?	
7. a) Was your patient referred to you? If so, please give name and address of doctor concerned. b) Name and address of doctor(s) who attended to your patient prior to seeing you. c) Name and address of doctor(s) concurrently treating your patient with you for this condition	Consultation Dates Name and Address of Doctor(s) a) b) c)

d) Was your patient referred to any other doctor(s) by yourself? Please give name and address of the doctor(s).	d)
8. In your opinion, was this discoid lupus?	Yes ☐ No ☐
a) Please confirm the diagnosis of SLE.	a)
b) Would you know the aetiology of the disease? E.g. genetic factors, drug induced etc.	b)
c) Had you performed any biopsies? Is so, please give details of histopathology report.	c)
d) Please give details of haematological investigation.	d)
e) Was there a systemic involvement?	e)
f) Was there any involvement of heart, kidneys or central nervous system? If yes, please give details.	f)
9. a) Please state date of diagnosis.	a)
b) Name and address of doctor who established the diagnosis.	b)
c) Was your patient informed of the diagnosis? If so, when and by whom?	c)

10. Please give details of your patient's smoking habits, both past and present. a) Does the patient smoke? i) If "Yes", how many sticks does the patient smoke in a day? ii) What is the exact duration? b) If "No", is the patient a non-smoker? c) If he was a smoker in the past, then when did the patient stop smoking?	 a) i) ii) b) c)

11. Has the patient ever been diagnose / suffered from any of the following:	Diagnosis	Date of Diagnosis / Onset	Name and Address of Doctor(s) Consulted	Dates of Treatment Consulted
a) Hypertension.	a)			
b) Diabetes Mellitus.	b)			
c) Cardiovascular Disease.	c)			
d) Other illness(es) / injuries. If so, please provide diagnosis, date of diagnosis / onset, names and addresses of all doctors consulted and dates of consultation.	d)			

12. Please give any other information which you feel would be helpful in the assessment of your patient's claim.	

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: _____

For Office Use Only

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