هوڠ ليوڠ م.س.أ.ج. تكافل
HongLeong MSIG Takaful

CF09900001

Certificate No.: _____ Claim No.: _____

MEDICAL ATTENDANT'S REPORT ON TOTAL AND PERMANENT DISABILITY / OLD AGE DISABLEMENT CLAIM

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

1. a) Name of Patient.	
b) I/C No.	
c) Date of Birth.	Date: (dd/mm/yyyy)
d) Present Occupation. (If more than one, please state all)	
2. a) Please describe the exact details of your patient's present condition.	
b) Date last seen by you.	Date: (dd/mm/yyyy)
3. a) Date of disability began.	Date: (dd/mm/yyyy)
b) Cause of disability.	
4. a) When did your patient first consult you for the condition?	Date: (dd/mm/yyyy)
b) Symptoms presented at first consultation.	
c) Date of symptoms first appeared prior to first consultation.	Date: (dd/mm/yyyy)
d) Date of patient's last consultation with you.	Date: (dd/mm/yyyy)
5. a) Please give full details of the diagnosis.	
b) Date of diagnosis.	Date: (dd/mm/yyyy)
c) Name and address of doctor who established the diagnosis.	
d) Was your patient informed of the diagnosis? If yes, when and by whom?	Yes ☐ Doctor's name : Date : (dd/mm/yyyy) No ☐
6. Had your patient suffered any previous episodes of the condition or any other conditions leading to it or relating to it? If yes, please give details.	Yes ☐ Details: No ☐
7. a) Was your patient referred to you? If yes, please give name and address of doctor concerned.	
b) Name and address of doctor(s) who attended to your patient prior seeing you.	
c) Name and address of doctor(s) concurrently treating your patient with you for the condition.	
d) Was your patient referred to any other doctor(s) by yourself? Please give name and address of the doctor(s).	

8. If the condition was due to an accident, please state: a) Date and time of accident. b) Full circumstances of accident.	a) Date: (dd/mm/yyyy) Time: (am/pm) b)
9. a) Had the patient's condition improved, deteriorated or remained the same on last consultation date?	Improved ☐ Deteriorated ☐ Remained the same ☐
b) Was there any rehabilitation or physiotherapy that would help to improve the patient's condition? If yes, please give details.	Yes ☐ Details: No ☐
c) Is the patient's current condition / disability expected to be permanent?	Yes ☐ No ☐
d) If the condition is not permanent, to what extent is recovery expected and when is recovery expected to begin?	
e) Please state the date when patient was medically boarded out, if any.	Date: (dd/mm/yyyy)
10. a) Can the patient resume his/ her last occupation? If yes, please give details on the extent and limitations.	Yes ☐ Details: No ☐
b) Can the patient perform any work for compensation or profit? If yes, please give details on the extent and limitations.	Yes ☐ Details: No ☐

11. Please grade your patient's ability to perform the following Activities of Daily Living (ADL) specified in the table below by ticking (√) the appropriate columns.

Date of assessment (dd/mm/yyyy): ☐

Activities of Daily Living (ADL)	Complete Limitation	Substantial Limitation	Minor Limitation with Assistance required, i.e. use of an Aid or Appliance	No Limitation
a) Transfer Getting in and out of a chair without requiring physical assistance.				
b) Bathing The ability to wash in bath or shower or by other means to maintain personal cleanliness.				
c) Mobility The ability to move from room to room without requiring any physical assistance.				
d) Continence The ability to voluntarily control bowel and bladder functions as to maintain personal hygiene.				
e) Dressing Putting on and taking off all necessary items of clothing without requiring the assistance of another person.				
f) Toileting Getting to and from the toilet, transferring on and off the toilet and associated personal hygiene.				
g) Eating All tasks of getting food into the body once it has been prepared.				

12. Please assess the patient's degree of limitation in performing the functional abilities specified in the table below by ticking (√) the appropriate columns.

Date of assessment (dd/mm/yyyy):

Ability	Current Ability				Expected Ability in 12 months			Expected Long Term Ability		
	Complete Limitation	Substantial Limitation	Minor Limitation with Assistance required	No Limitation	Deteriorate	Stable	Improve	Deteriorate	Stable	Improve
Climbing stairs										
Lifting & carrying										
Working with light weights										
Working with heavy weights										
Right hand										
Left hand										
Right leg										
Left leg										
Hearing										
Visual										
Speech										
Social Interaction										
Memory										
Attention										
Safety judgement										

13. Had the patient been treated for any of the following illnesses? If yes, please provide additional information as per the table below.

	Date of Diagnosis/ Onset (dd/mm/yyyy)	Name & address of Doctor(s) consulted	Dates of Consultation (dd/mm/yyyy)
a) Hypertension			
b) Diabetes Mellitus			
c) Cardiovascular Disease			
d) Other Illnesses / Injuries Please specify:			
i.	i.	i.	i.
ii.	ii.	ii.	ii.

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

Signature: _____

Name (in block capitals): _____

Qualification: _____

Contact No.: _____

Date: _____(dd/mm/yyyy)

Official Stamp: