هوغ ليوغ عيم.ايس.اءي.جي.تكافل
HongLeong MSIG Takaful

CF07800001

Certificate No.: _____ Claim No.: _____

MEDICAL ATTENDANT'S REPORT ON DREAD DISEASE CLAIM

(Coma)

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) 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)
4. 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 : No ☐ Date : (dd/mm/yyyy)
5. 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 ☐
6. 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).	

7. a) Did your patient have any reaction or response to external stimuli?	Yes ☐ No ☐
b) Was there an internal needs requiring the use of life support systems persisting continuously for at least 96 hours?	Yes ☐ No ☐
c) Was your patient's condition resulting in a permanent neurological deficit lasting more than 30 days?	Yes ☐ No ☐
d) Was your patient's condition related to self-inflicted injury, alcohol or drug abuse? If yes, please give details.	Yes ☐ Details : No ☐

8. Kindly fill up your patient's record of Glasgow Coma Scale as below:

Date	Time	Glasgow Coma Scale			
		Eye Response	Motor Response	Verbal Response	Total Score

9. 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. ii.	 i. ii.	 i. ii.	 i. ii.

10. 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: