هوڠ ليوڠ عيم.ايس.اءي.جي. تكافل
Hong Leong MSIG Takaful

CF08500001

Certificate No.: ______________________ Claim No.: ______________________

MEDICAL ATTENDANT'S REPORT ON DREAD DISEASE CLAIM

(HIV due to Blood Transfusion / Full Blown AIDS)

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 : Date : (dd/mm/yyyy) No ☐
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).	

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7. Please answer the questions below in respect of the patient's condition.

a) HIV due to Blood Transfusion i. Was the infection with Human Immunodeficiency Virus (HIV) through a blood transfusion? If yes, provide reasons why a blood transfusion was given and attach a copy of HIV antibody test result.	Yes ☐ Reason: No ☐
ii. Name and address of the institution that provided the blood transfusion and has been established to be the source of the infection.	
iii. Can the abovementioned institution trace the origin of the HIV tainted blood?	Yes ☐ No ☐
iv. Date the tainted blood transfusion was given.	Date: (dd/mm/yyyy)
v. Was your patient a haemophiliac or belong to any of the high risk groups? Please give details if of high risk groups.	Haemophiliac ☐ No ☐ High risk groups ☐ Details:
b) Full Blown AIDS i) Any HIV antibody test done? Please provide a copy of the report.	Yes ☐ No ☐
ii) Did your patient suffer any of the below symptom / illness?	
1. CD4 cell count of less than two hundred (200).	1. Yes ☐ No ☐
2. Weight loss of more than ten (10) percent of body weight.	2. Yes ☐ No ☐
3. Kaposi Sarcoma.	3. Yes ☐ No ☐
4. Pneumocystic Carinii Pneumonia.	4. Yes ☐ No ☐
5. Progressive Multifocal Leukoencephalopathy.	5. Yes ☐ No ☐
6. Active Tuberculosis.	6. Yes ☐ No ☐
7. Less than one thousand (1000) lymphocytes.	7. Yes ☐ No ☐
8. Malignant Lymphoma.	8. Yes ☐ No ☐
8 a) Any counseling / advice given to the patient? If yes, please provide date.	Yes ☐ Date: (dd/mm/yyyy) No ☐
b) Any counseling / advice given to the spouse? If yes, please provide date.	Yes ☐ Date: (dd/mm/yyyy) No ☐
9. Had any other investigative tests or procedures been performed? If yes, please give details and enclose a copy of the report.	Yes ☐ Details: No ☐

10. 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.

11. 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: