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

CF09100001

Certificate No.: _____ Claim No.: _____

MEDICAL ATTENDANT'S REPORT ON DREAD DISEASE CLAIM

(Bacterial Meningitis / Encephalitis)

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).	
7. a) Was there any functional impairment? If yes, please give details.	Yes ☐ Details: No ☐
b) Is the functional impairment permanent?	Yes ☐ No ☐
8. Was the diagnosis existed in the presence of HIV infection?	Yes ☐ No ☐
9. Please give details of the diagnostic tests performed with results e.g. Cerebrospinal fluid test, CT Scan, ECG, blood cultures.	
10. Was the Meningitis caused by: a) Bacterial?	Yes ☐ No ☐
b) Virus?	Yes ☐ No ☐
c) Other forms of Meningitis? If yes, please give details.	Yes ☐ Details: No ☐

11. Was the Meningitis causing inflammation to: a) Membrane of the brain?	Yes ☐ No ☐
b) Spinal Cor	Yes ☐ No ☐
c) Other sites? Please specify.	Yes ☐ No ☐ Details:

Please complete the section below.

12. 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.				

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. ii.	 i. ii.	 i. ii.	 i. 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: