HongLeong هوڠ ليوڠ عيم.ايس.اءي.جي. تكافل MSIG Takaful

CF08900001

Certificate No.: _____ Claim No.: _____

## MEDICAL ATTENDANT'S REPORT ON DREAD DISEASE CLAIM

## (Major Organ / Bone Marrow Transplant)

This report is to be completed by a registered medical practitioner at the own expense of claimant. Please tick in the box provided if applicable.

| | |
|---|---|
| 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. a) Which was the organ involved? | |
| b) Full details of operation performed. | |
| c) Date of operation performed. | Date: (dd/mm/yyyy) |
| d) For bone marrow transplant, was the human bone marrowing hematopoietic stem cells preceded by total bone marrow ablation? If no, please elaborate further. | Yes ☐ No ☐ Please elaborate: |
| e) Hospital and name of surgeon undertook the surgical procedure. | |
| 8. Had any other investigative tests or procedures been performed? If yes, please give details and please enclose the supporting documents. | Yes ☐ Details: No ☐ |

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<br>Please specify:<br>i.<br>ii. | <br><br>i.<br>ii. | <br><br>i.<br>ii. | <br><br>i.<br>ii. |

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|---|---|
| 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: