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

CF07200001

Certificate No.: _____ Claim No.: _____

MEDICAL ATTENDANT'S REPORT ON DREAD DISEASE CLAIM

(Blindness / Deafness / Loss of Speech)

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 : No ☐ (dd/mm/yyyy)
e) How did you confirm the diagnosis? Kindly enclose a copy of report.	
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. 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)

8. Please give details of the underlying cause on blindness / deafness / loss of speech?	
9. Please answer the questions below in respect of the patient's condition.	
a) Blindness / Total Loss of Sight	
i. Is the loss of vision permanent?	Yes ☐ No ☐
ii. Is the loss of vision total loss?	Yes ☐ No ☐
iii.What is the vision in the right eye and left eye?	Right eye: Left eye:
b) Deafness / Total Loss of Hearing	
i. Is the loss of hearing permanent?	Yes ☐ No ☐
ii. Please advise on the hearing loss (express in decibels).	
iii. Had the investigation tests in the form of an audiometry and sound threshold test been performed? If yes, please give details.	Yes ☐ Details: No ☐
c) Loss of Speech	
i. Is the loss of speech permanent?	Yes ☐ No ☐
ii. Was the patient suffered from loss of speech for a continuous period of 6 or 12 months? If yes, since when?	Yes for 6 months ☐ Since when : (dd/mm/yyyy) No ☐ Yes for 12 months ☐ Since when : (dd/mm/yyyy) No ☐
iii. Is the loss of speech total loss?	Yes ☐ No ☐
10. Is there any possibility of a surgical procedure or any other form of corrective treatment? If yes, please give details.	Yes ☐ Details: No ☐
11. Had any other investigative tests or procedures been performed? If yes, please give details and enclose a copy of report.	Yes ☐ Details: No ☐

12. 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.

13. 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: