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

CF07100001

Certificate No.: _____ Claim No.: _____

MEDICAL ATTENDANT'S REPORT ON DREAD DISEASE CLAIM

(Benign Brain Tumour / Brain Surgery)

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. 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. a) Please give details of the type of tumour.	
b) Exact location of the tumour in the brain.	
c) What was the staging of tumour? Please enclose a copy of the CT Scan or MRI report.	
d) Was the brain tumour life threatening?	Yes ☐ No ☐
e) Did the brain tumour cause damage to the brain?	Yes ☐ No ☐
f) Were there any signs of increased intracranial pressure?	Yes ☐ No ☐
9. Did your patient undergo any surgery / procedure of the brain? If yes, please give details. a) Date of surgery / procedure. b) Details of the surgery / procedure. c) Name and address of the surgeon who performed the surgery / procedure on your patient.	Yes ☐ No ☐ a) Date: (dd/mm/yyyy) b) c)
10. Had any other investigative tests or procedures been performed? If yes, please give details and enclose a copy of the report.	Yes ☐ Details: No ☐

11. 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.

12. 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: