



CF08800001

Certificate No.: _____

Claim No.: _____

**MEDICAL ATTENDANT'S REPORT ON DREAD DISEASE CLAIM
(Major Head Trauma)**

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 <input type="checkbox"/> Doctor's name : _____ No <input type="checkbox"/> Date : _____
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 <input type="checkbox"/> Details: _____ No <input type="checkbox"/>
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) If the condition was due to an accident, please state: i. Date and time of accident. ii. Full circumstances of accident.	i. Date: (dd/mm/yyyy) Time: (am/pm) ii.
b) Was there any contributory circumstances which led to the accident, e.g. under influence of alcohol, fits etc? If yes, please give details.	Yes <input type="checkbox"/> Details: _____ No <input type="checkbox"/>
8. a) Was a skull fracture, brain damage or cerebral contusion evident? If yes, please give details.	Yes <input type="checkbox"/> Details: _____ No <input type="checkbox"/>
b) Was a brain CT Scan or MRI scan performed? If yes, please give details.	Yes <input type="checkbox"/> Details: _____ No <input type="checkbox"/>
c) Was there permanent neurological deficit causing significant functional impairment? If yes, please give details e.g. dates and duration.	Yes <input type="checkbox"/> Dates and duration (dd/mm/yyyy): _____ No <input type="checkbox"/>
d) Is it likely to be permanent?	Yes <input type="checkbox"/> No <input type="checkbox"/>

9. 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.				

10. Had any other investigative tests or procedures been performed? If yes, please give details and please enclose the supporting documents.

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