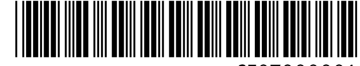
هوڠ ليوڠ عيم.ايس.اءي.جي. تكافل
HongLeong MSIG Takaful


CF07000001

Certificate No.: ______________________________ Claim No.: ______________________

MEDICAL ATTENDANT'S REPORT ON DREAD DISEASE CLAIM

(Apallic Syndrome i.e. Persistent Vegetative State (PVS) / Motor Neurone Disease)

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. Please answer the questions below in respect of the patient's condition.

a) Apallic Syndrome i.e. Persistent Vegetative State (PVS)

i. Please give full details of the necrosis of brain cortex.	
ii. Is the patient: a. in a vegetative state? b. condition permanent? c. having mental reduction?	 a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐
iii. Does the patient's social function require continuous supervision?	Yes ☐ No ☐
iv. Please confirm the following: a. Is there awareness of self or environment? b. Is patient able to interact with others? c. Any evidence of sustained, reproducible, purposeful, or voluntary behavioural responses to visual, auditory, tactile, or noxious stimuli? d. Any evidence of language comprehension or expression? e. Does the patient have bowel and bladder incontinence?	 a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐ e. Yes ☐ No ☐

b) Motor Neurone Disease

i. Please describe the neurological abnormalities that your patient had experienced.

Neurological Abnormalities	Please tick (√) the relevant column		Duration
	Yes	No	
Spiral muscular atrophy			
Progressive bulbar palsy			
Amyotrophic lateral sclerosis			
Primary lateral sclerosis			

ii. What treatment is your patient currently receiving?	
iii.Had the patient's condition resulting in permanent neurological deficit? If yes, please give details.	Yes ☐ Details: No ☐
8. Had any other investigative tests or procedures been performed? If yes, please give details and enclose a copy of the report.	Yes ☐ Details: No ☐

9. Had the patient been treated for any of the following illnesses? If yes, please provide additional information as per 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

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: