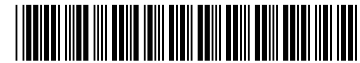
هوڠ ليوڠ ميسيڬ تكافل

HongLeong MSIG Takaful



CF09400001

Certificate No.: ______________________ Claim No.: ______________________

MEDICAL ATTENDANT'S REPORT ON DREAD DISEASE CLAIM

(Parkinson's 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. a) Please describe the neurological abnormalities that your patient had experienced.	
b) How long had your patient been experiencing the abnormalities and had they been present continuously?	Duration: Present Continuosly: Yes ☐ No ☐
c) Is your patient currently well controlled with medication prescribed? If yes, please give details of your patient's medication.	Yes ☐ Details of medication: No ☐ Please elaborate further:

d) Please enumerate the signs which indicate that your patient's condition was getting worse despite adequate medication.	
8. Was your patient's condition induced by drugs, alcohol or toxic? If yes, please give details.	Yes ☐ Details: No ☐

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. Was the patient's inability in performing the above Activities of Daily Living (ADL) confirmed as permanent?	Yes ☐ No ☐
11. Had any other investigative tests or procedures been performed? If yes, please give details and enclose a copy of the 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: