هوغ ليوغ عيم.ايس.اءي.جي.تكافل
HongLeong MSIG Takaful

CF09200001

Certificate No.: _____ Claim No.: _____

MEDICAL ATTENDANT'S REPORT ON DREAD DISEASE CLAIM

(Multiple Sclerosis / Poliomyelitis / Progressive scleroderma)

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 that time.	
c) Date of symptoms first appeared.	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) Multiple Sclerosis	
i. Was there a history of repeated relapse and remission of steady progressive disability?	Yes ☐ No ☐
ii. Were there lesions producing well-defined neurological deficits involving the optic nerves, brain stem and spinal cord? If yes, please give details.	Yes ☐ Details: No ☐
iii. Were there signs and symptoms of multiple or discrete lesions? Please elaborate.	Yes ☐ Details: No ☐
iv. Date of returned to normal activities and or your patient's present limitation, physical and mental.	Date: (dd/mm/yyyy)
v. Was the multiple neurological deficits resulting in impairment of motor and sensory functions occurring over a continuous period of six (6) months? If yes, since when?	Yes ☐ Since when : (dd/mm/yyyy) No ☐
b) Poliomyelitis	
i. Please give details of neurological deficit e.g. paralysis or asymmetrical paralysis.	
ii. Did your patient suffer from impaired motor function or respiratory weakness?	Yes ☐ No ☐
iii. Had any other investigative tests or procedures been performed? If yes, please give details and enclose a copy of the report.	Yes ☐ Details: No ☐
iv. Is the poliomyelitis caused by poliovirus?	Yes ☐ No ☐
v. Did the poliomyelitis result in any paralysis of the limb muscles or respiratory muscles for a continuous period of 3 months? If yes, since when.	Yes ☐ Since when : (dd/mm/yyyy) No ☐
c) Progressive scleroderma	
i. Was there any progressive diffuse fibrosis in the skin, blood vessels or visceral organs? Please give details.	
ii. Was there any biopsy or serological evidence done to confirm the diagnosis? If so, please give details and enclose a copy of report.	
iii. Is the condition related to either: a. Localised scleroderma b. Eosinophilic fasciitis c. CREST syndrome	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐

8. 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.

9. 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: