هوڠ ليوڠ عيم.ايس.اءي.جي. تكافل

HongLeong MSIG Takaful

CF06800001

Certificate No.: _____ Claim No.: _____

MEDICAL ATTENDANT'S REPORT ON DREAD DISEASE CLAIM

(Angioplasty and Other Invasive Treatments For Coronary Artery Disease / Coronary By-Pass Surgery / Heart Attack /Other Serious Coronary Artery 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 complete the section below if your patient was diagnosed with a Heart Attack.

a) Please give full details of any chest pain prior to the attack.	
b) Was an ECG performed? If yes, please give date and details of the ECG changes. Please enclose a copy of the ECG results.	Yes ☐ Details: Date : (dd/mm/yyyy) No ☐
c) Were cardiac enzymes measured? If yes, please give details of cardiac enzymes levels. Please enclose a copy of the test result.	Yes ☐ Details: No ☐
d) Were Troponin T tests measured? If yes, please give details of Troponin T level. Please enclose a copy of the test result.	Yes ☐ Details: No ☐
e) Was the condition classified as acute coronary syndrome?	Yes ☐ Details: No ☐
f) i. Was a percutaneous procedure performed? ii. If yes, had the percutaneous procedure for Coronary Artery Disease caused a rise in cardiac biomarkers? Please give details.	i. Yes ☐ No ☐ ii. Yes ☐ No ☐ Details:

8. Please complete the section below relating to Coronary Artery Disease.

a) i. Details of exact procedure / surgery performed. ii. Date of procedure / surgery. iii.Hospital and name of surgeon who performed the procedure / surgery. iv.What was the indication for the procedure done? v. If patient's condition required Coronary Artery By-Pass Surgery, what are the number and site of grafts?	i. ii. Date: (dd/mm/yyyy) iii. iv. v.
b) Was a coronary angiogram performed? If yes, please give date and details. Please enclose a copy of the report. i. Date ii. Please specify the coronary arteries involved and the percentage of stenosis:	i. Date: (dd/mm/yyyy) ii.

Major Coronary Artery	Percentage (%) of stenosis (Exclude their branches)
Left Main Stem	
Left Anterior Descending Artery (LAD)	
Circumflex Artery	
Right Coronary Artery (RCA)	

9. Had any other investigative tests or procedures been performed? If yes, please give details and enclose a copy of report.	Yes ☐ Details: No ☐

10. 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.

11. 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: