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

CF08300001

Certificate No.: _____ Claim No.: _____

MEDICAL ATTENDANT'S REPORT ON DREAD DISEASE CLAIM

(Fulminant Viral Hepatitis / Chronic Autoimmune Hepatitis)

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 : No ☐ Date : (dd/mm/yyyy)
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) Fulminant Viral Hepatitis	
i. Type(s) of virus involved.	
ii. Please confirm the patient's condition. a. Was there a sub massive to massive necrosis of the liver? b. Was there a rapidly decreasing liver size? c. Was there a rapidly deteriorating liver function tests? d. Was there any deepening jaundice?	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐
iii. Had liver function test, biopsy and ultrasound been performed? If yes, please give details and enclose a copy of the report.	Yes ☐ Details: No ☐
b) Chronic Autoimmune Hepatitis	
i. Is there Hypergammaglobulinaemia?	Yes ☐ No ☐
ii. Is there presence of at least one of the following auto-antibodies? a. Anti-Nuclear Antibody; b. Anti-smooth muscle antibodies; c. Anti-actin antibodies; d. Anti-LKM-1 antibodies; e. Anti- LC1 antibodies; or f. Anti-SLA/LP antibodies	a. Yes ☐ No ☐ b. Yes ☐ No ☐ c. Yes ☐ No ☐ d. Yes ☐ No ☐ e. Yes ☐ No ☐ f. Yes ☐ No ☐
iii. Is there any liver biopsy done to confirm diagnosis of auto-immune hepatitis? Please attach a copy of the report.	
iv. Has the patient been put on continuous Immunosuppressive therapy for a period of at least 6 months?	
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. Has 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.

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: