ZURICH Takaful

| Claim No. (For Office Use Only) | | | | | | | | | | |
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# Confidential Medical Questionnaire – Brain, Nerve and Neurological Related Conditions

**Instructions & Important Note:**

- This form must be completed by the attending doctor (who is a registered Medical Practitioner qualified and licensed to practice western medicine and who is practicing within the scope of his / her licensing / training) at the claimant's expense.
- The attending doctor is required to tick (√) & complete the relevant part(s) below.
- If there is insufficient space, please use a separate sheet(s) of paper for your response.

## Part A : Details of Patient ( Person Covered ) - This section is COMPULSORY to be completed for all Critical Illnesses

| | | | |
|---|---|---|---|
| 1. Name | | 2. Gender | [ ] Male [ ] Female |
| 3. New NRIC Number | | 4. Old IC No. / Passport No / Birth Certificate No. | |
| 5. Age | | 6. Certificate Number | |

Important: Please enclose copies of all reports including X-rays, CT scans, any other imaging studies, laboratory evidence, surgery report, Histopathology examination (HPE), biopsy report, electroencephalogram (EEG) report, Mini Mental State Examination (MMSE) report, Glasgow Coma Scale report, electromyography (EMG), nerve conduction studies, CSF study etc. and any relevant hospital reports that are available.

## Part B : Details of Diagnosis - Question 1 to 7 are COMPULSORY to be completed for all Critical Illnesses

1 a Are you the patient's regular doctor? [ ] Yes [ ] No

b If Yes, since when? D D M M Y Y

2 a When were you first consulted for this illness? D D M M Y Y

b What were the symptoms / complaints? _____

_____

c Date of onset of symptoms / complaints D D M M Y Y

**Diagnosis**

3 a Full and exact diagnosis _____

_____

b When was the illness FIRST diagnosed? D D M M Y Y _____ am / pm

c When was the patient / patient's next of kin first informed of the diagnosis? D D M M Y Y _____ am / pm

d What was / were the underlying cause(s)? _____

_____

4 a Details of investigations performed _____

_____

b Details of treatment rendered _____

_____

c Date of last consultation D D M M Y Y

d The patient's condition as at last consultation date _____

_____

**Details of hospitalisation**

5 a Name of Hospital _____

b Date and time of admission D D M M Y Y _____ am / pm

c Date and time of discharge D D M M Y Y _____ am / pm

d Name of surgery performed _____

e Date of surgery D D M M Y Y

f Was the patient admitted to Intensive Care Unit (ICU)? ☐ Yes ☐ No

If "Yes", how many days: _____

g Was the patient placed on life support measures? ☐ Yes ☐ No

If "Yes", how many days: _____

Which of the following essential life support was used?

☐ Invasive ventilator-assisted breathing through tracheal intubation
☐ Extracorporeal membrane oxygenation (ECMO)
☐ Intra-aortic balloon pump (IABP)
☐ Hemofiltration, haemodialysis, peritoneal dialysis or total parenteral nutrition
☐ Others, please specify: _____

6 Is the current diagnosis related to:

☐ Congenital
☐ Hereditary
☐ Due to Alcohol / Drugs
☐ Self-inflicted Injury
☐ Mental / Emotional / Sleeping Disorder
☐ Pregnancy / Childbirth / Miscarriage
☐ Acquired Immune Deficiency Syndrome (AIDS)
☐ Human Immuno-deficiency Virus (HIV) Infection
☐ Traumatic Injury
☐ None of the above

7 To your knowledge, has the patient suffered from any of the following illness / condition?

| | Yes | No | Date of Onset | Name of Doctor / Clinic / Hospital |
|---|---|---|---|---|
| a Hyperlipidemia | | | | |
| b Hypertension | | | | |
| c Diabetes | | | | |

d Any Other Illness or Disability, please specify. _____

## Part C : Details of Critical Illness - This section is applicable to SPECIFIC CRITICAL ILLNESS only

8 **Alzheimer's Disease / Severe Dementia / Irreversible Organic Degenerative Brain Disorders**

a Type of Disease

☐ Alzheimer's Disease
☐ Moderately Severe Alzheimer's Disease
☐ Dementia
☐ Severe Dementia
☐ Irreversible Organic Degenerative Brain Disorders
☐ Others, please specify: _____

b Any evidence of deterioration or loss of intellectual capacity or cognitive function? ☐ Yes ☐ No

c Any abnormal behaviour resulting in significant reduction in mental and social functioning? ☐ Yes ☐ No

d Was there any permanent clinical loss of ability to do all of the following?
(i) Remember ☐ Yes ☐ No
(ii) Reason ☐ Yes ☐ No
(iii) Perceive, understand, express and give effect to ideas ☐ Yes ☐ No

e Please provide the details of examinations performed:
(i) Date of assessment performed | D | D | M | M | Y | Y |

(ii) Mini Mental State Examination (MMSE) _____ out of 30 points

(iii) Any other equivalent tests, please specify. _____

f Does the patient require continuous supervision? ☐ Yes ☐ No

If "Yes", since when: _____ (DD/MM/YYYY)

Please give details: _____

g Was the deterioration or loss of intellectual capacity or abnormal behaviour arises from the following?
(i) Neurosis ☐ Yes ☐ No
(ii) Psychiatric illness ☐ Yes ☐ No
(iii) Drug or alcohol related brain damage ☐ Yes ☐ No
(iv) Head injury related brain damage ☐ Yes ☐ No

If "Yes", please give details: _____

h Was the condition medically documented for at least three months since diagnosis date? ☐ Yes ☐ No

If "Yes", provide details / basis of evaluation (last evaluated) and the progression of patient's Alzheimer's Disease / dementia condition since first seen.

_____

_____

## 9 Apallic Syndrome

a Was there any presence of universal necrosis of the brain cortex with the brainstem remaining intact? ☐ Yes ☐ No

b Please describe the neurological sequelae

_____

_____

c Was the condition persisted for at least one month since diagnosis date? ☐ Yes ☐ No

If "Yes", please state the duration for which it has persisted and supported with a copy(ies) of medical reports. (e.g. EEG)

_____

## 10 Bacterial Meningitis / Encephalitis

a What was the causative agent of the infection?
☐ Bacterial
☐ Virus
☐ Others, please specify: _____

b Was the disease causing inflammation of the membranes of the brain or spinal cord? ☐ Yes ☐ No

c Was there any significant neurological deficit? ☐ Yes ☐ No

If "Yes", please give details: _____

d Is the neurological deficit permanent? ☐ Yes ☐ No

e Was the patient HIV positive? ☐ Yes ☐ No

f Was the disease a result of HIV infection? ☐ Yes ☐ No

g For bacterial meningitis, was there a presence of bacterial infection in the cerebrospinal fluid by lumbar puncture? ☐ Yes ☐ No

h Did the patient require 72 hours of hospitalisation? ☐ Yes ☐ No

## 11 Brain (Aneurysm) Surgery / Cerebral Shunt Insertion

a Did the patient undergo surgery of the brain? ☐ Yes ☐ No

b Which of the following surgical procedure performed?

- ☐ Craniotomy
- ☐ Burr Hole
- ☐ Transsphenoidal
- ☐ Endoscopic Assisted Procedures
- ☐ Endovascular Repair or Procedures
- ☐ Other Minimal Invasive Procedures
- ☐ Other procedure, please specify: _____

c Date of surgery | D | D | M | M | Y | Y |

d Reason for surgery _____

e Was the surgery performed due to injuries sustained during an accident? ☐ Yes ☐ No

f Was a cerebral shunt implanted during the surgery? ☐ Yes ☐ No

If "Yes", please give details: _____

## 12 Benign Brain Tumour

a Where was the location of the tumour? _____

b What is the nature of the tumour?

- ☐ Benign
- ☐ Malignant

Please state the extent of the tumour lesion and stage.
*(Note: Please also state the staging system used.)*

_____

c Has it caused damage to the brain? ☐ Yes ☐ No

If "Yes", please give details: _____

d Was the presence of the underlying tumour confirmed by CT scan, MRI or other imaging studies? ☐ Yes ☐ No

If ''Yes'', please enclose copies of all investigation performed, e.g. biopsy results, cytology reports, CT scan, MR imaging etc.

e Was the tumour life threatening?

☐ Yes ☐ No

If "Yes", please give details: _____

f Were there characteristic signs of intra-cranial pressure?

☐ Yes ☐ No

If "Yes", were the below symptoms / signs present?

| | | |
|---|---|---|
| Papilloedema | ☐ Yes | ☐ No |
| Mental symptoms | ☐ Yes | ☐ No |
| Seizures | ☐ Yes | ☐ No |
| Sensory impairment | ☐ Yes | ☐ No |

Other, please specify: _____

g Was the neurological deficit permanent with persisting clinical symptoms?

☐ Yes ☐ No

If "Yes", please give details: _____

h Has the tumour been surgically removed?

☐ Total removal
☐ Partial removal
☐ No removal

i Is the diagnosis falling within any of the following conditions?

☐ Cysts
☐ Granulomas
☐ Malformations in or of the arteries or veins of the brain
☐ Haematomas
☐ Tumours in the pituitary gland
☐ Tumours in the spine
☐ Tumours of the acoustic nerve

## 13 Coma

a Was there any reaction or response to external stimuli or internal needs?

☐ Yes ☐ No

If "No", how long was the patient in a state of coma, with no response to external stimuli or internal needs?

_____ hours / _____days since _____ (DD/MM/YYYY)

b Was the patient placed on life support measures?

☐ Yes ☐ No

If “Yes”, for how long?

_____ hours / _____days

c Are there any permanent neurological deficits of more than 30 days?

☐ Yes ☐ No

If "Yes", please give details: _____

d What is the extent of coma under the Glasgow Coma Scale?

_____

e Is the coma resulting from any of the following?

☐ Alcohol
☐ Drug abuse / misuse
☐ Self-inflicted injury
☐ Medically induced
☐ None of the above

## 14 Major Head Trauma

a Date of injury

| D | D | M | M | Y | Y |
|---|---|---|---|---|---|
| | | | | | |

b Details of circumstance leading to injury

_____

_____

c What is the exact location and extent of the head injury?

_____

_____

d Was any surgery performed?

☐ Yes ☐ No

If "Yes", please give details of surgical procedure:

_____

e Details of functional impairment and how long the impairment has lasted from the date of trauma or injury

| Impairment | Start Date (DD/MM/YYYY) | Last Assessment Date (DD/MM/YYYY) |
|---|---|---|
| | | |
| | | |
| | | |

f Is such an impairment expected to be permanent?

☐ Yes ☐ No

g Is the patient permanently bedridden as a result of the head trauma?

☐ Yes ☐ No

## 15 Motor Neuron Disease

a Type of Motor Neuron Disease

☐ Spinal muscular atrophy
☐ Progressive bulbar palsy
☐ Amyotrophic lateral sclerosis
☐ Primary lateral sclerosis
☐ Others, please specify the exact diagnosis: _____

b Please describe the neurological sequelae

_____

_____

c Are these sequelae permanent?

☐ Yes ☐ No

d Is the patient currently:

☐ Ambulatory
☐ Confined at home
☐ Confined at hospital
☐ Confined at bed
☐ Subject to some other restriction in movement or lifestyle?
If so, please give details: _____

## 16 Multiple Sclerosis

a Were there any symptoms referable to tracts (white matter) involving the optic nerves, brain stem and spinal cord, producing well-defined neurological deficits?

☐ Yes ☐ No

If "Yes", please give details: _____

b Was there any evidence of multiplicity or discrete lesions on imaging studies?

☐ Yes ☐ No

If "Yes", please enclose copies of reports.

c Were the multiple neurological deficits resulting in demyelination and impairment of motor and sensory functions occurring over a continuous period of at least six (6) months?

☐ Yes ☐ No

If "Yes", since when: _____ (DD/MM/YYYY)

d Was there a history of exacerbations and remissions of the said symptoms or neurological deficits?

☐ Yes ☐ No

If "Yes", please indicate number of exacerbations since diagnosis:

_____

e Was the neurological damage caused by the following?

(i) Systemic Lupus Erythematosus ☐ Yes ☐ No

(ii) Human Immuno-deficiency Virus (HIV) Infection ☐ Yes ☐ No

If ''Yes'', please provide the diagnosis date: _____ (DD/MM/YYYY)

f Was the disease a result of a single nerve affections? ☐ Yes ☐ No

g Details of investigations performed

| Investigation / Test | Finding / Test Result |
|---|---|
| | |
| | |
| | |

## 17 Muscular Dystrophy

a Type of Muscular Dystrophy

☐ Duchenne's
☐ Becker
☐ Limb Girdle Muscular
☐ Family history of other affected individuals
☐ Congenital
☐ Others, please specify: _____

b Which are the central / peripheral nerves involved? _____

c Was there any evidence of absence of sensory disturbance, normal cerebrospinal fluid and mild tendon reflex reduction? ☐ Yes ☐ No

If "Yes", please describe findings: _____

d Was the diagnosis confirmed by the following?

(i) An electromyogram ☐ Yes ☐ No

(ii) Muscle biopsy ☐ Yes ☐ No

(iii) CPK estimations ☐ Yes ☐ No

If "Yes", please enclose copies of reports.

e Has the condition medically documented for at least three months since diagnosis? ☐ Yes ☐ No

f Is the patient currently:

☐ Ambulatory
☐ Confined at home
☐ Confined at hospital
☐ Confined at bed
☐ Subject to some other restriction in movement or lifestyle?

If so, please give details: _____

## 18 Paralysis / Poliomyelitis

a Is there paralysis? ☐ Yes ☐ No

b What is the underlying cause of paralysis?

☐ Accident
☐ Sickness
☐ Self-inflicted injury
☐ Partial paralysis
☐ Temporary post-viral paralysis
☐ Psychological causes
☐ Guillain-Barre syndrome
☐ Others, please specify: _____

c Is the loss of use of the involved limbs considered total, permanent and irreversible?

☐ Yes ☐ No

If ''Yes'', since when: _____ (DD/MM/YYYY)

d For Poliomyelitis, was there evidence of infection by the poliovirus resulting in impairment of motor function or respiratory weakness?

☐ Yes ☐ No

19 **Parkinson's Disease**

a Can the patient's condition be controlled with medication?

☐ Yes ☐ No

b Are there signs of progressive impairment?

☐ Yes ☐ No

c What is the underlying cause of the disease?

☐ Idiopathic
☐ Drug-induced
☐ Toxins
☐ Others, please specify: _____

d Is the patient currently:

☐ Ambulatory
☐ Confined at home
☐ Confined at hospital
☐ Confined at bed
☐ Subject to some other restriction in movement or lifestyle?

If so, please give details: _____

20 **Stroke**

a Please describe the initial episode:
(i) Date of the episode

| D | D | M | M | Y | Y |
|---|---|---|---|---|---|
| | | | | | |

(ii) Nature of the episode

_____

_____

(iii) Duration of the acute symptoms

_____

b What is the underlying cause of the disease?

☐ Infarction of brain tissue
☐ Cerebral haemorrhage
☐ Embolization from an extracranial source
☐ Subarachnoid haemorrhage
☐ Others, please specify: _____

c Were there any changes seen in a CT scan or MRI?

☐ Yes ☐ No

If "Yes", please enclose copies of reports.

d Please describe the neurological sequelae

_____

_____

e Are these sequelae permanent?

☐ Yes ☐ No

f Is the condition related to the following?

☐ Transient ischemic attack
☐ Any reversible ischemic neurological deficit
☐ Vertebrobasilar ischemia
☐ Cerebral symptoms due to migraine
☐ Cerebral injury resulting from trauma or hypoxia
☐ Vascular disease affecting the eye or optic nerve or vestibular functions

## Part D : Neurological Examination Report – This section is COMPULSORY to be completed based on LATEST / CURRENT assessment

1 a Date when the patient's neurological impairments were first noted / onset

| D | D | M | M | Y | Y |
|---|---|---|---|---|---|
| | | | | | |

b Date of latest / current assessment

| D | D | M | M | Y | Y |
|---|---|---|---|---|---|
| | | | | | |

**Note: Question 2 to 8 are compulsory to be completed based on the patient's latest / current condition.**

2 Vision
(Visual Acuity Both Eye)

| | Right | Left |
|---|---|---|
| Normal | | |
| Impaired | | |
| Scores based on Metric Acuity | | |

Remarks: _____

3 Hearing
(For ENT Specialist Opinion, Audiometry)

| | Right | Left |
|---|---|---|
| Normal | | |
| Impaired | | |
| Scores based on Speech Reception Threshold (dB) | | |

Remarks: _____

4 Function of speech

- ☐ Clear and understandable
- ☐ Slurred
- ☐ Unable to speak
- ☐ Others, please specify: _____

5 Cognitive function

- ☐ Normal
- ☐ Poor comprehension
- ☐ Difficult with logic and reasoning
- ☐ Memory loss
- ☐ Others, please specify: _____

6 General Inspection:

a Is there any abnormal movement?
(Please explain in detail, if any)

_____

_____

_____

b Is there any muscle wasting?
(Please explain in detail, if any)

_____

_____

_____

7 Examination of Limbs:

Please indicate the muscle power of each joint in the boxes provided.
***(Lowest score: 0; Highest score: 5)***

a Upper Limbs

| | Right | Left |
|---|---|---|
| Shoulder | / 5 | / 5 |
| Elbow | / 5 | / 5 |
| Wrist | / 5 | / 5 |
| Grip | / 5 | / 5 |

b Lower Limbs

| | Right | Left |
|---|---|---|
| Hip | / 5 | / 5 |
| Knee | / 5 | / 5 |
| Ankle | / 5 | / 5 |

Remarks: _____

_____

_____

8 Assessment of Activities of Daily Living:

| | NO LIMITATION | LIMITED BUT CAPABLE | COMPLETELY INCAPABLE |
|---|---|---|---|
| a **Transfer** (Getting in and out of a chair without requiring physical assistance) | ☐ | ☐ | ☐ |
| b **Mobility** (The ability to move from room to room without requiring any physical assistance) | ☐ | ☐ | ☐ |
| c **Continence** (The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene) | ☐ | ☐ | ☐ |
| d **Dressing** (Putting on and taking off all necessary items of clothing without requiring assistance of another person) | ☐ | ☐ | ☐ |
| e **Bathing** (The ability to wash in the bath or shower (including getting in and out of the bath or shower) or wash by any other names) | ☐ | ☐ | ☐ |
| f **Eating** (All tasks of getting food into the body, once it has been prepared) | ☐ | ☐ | ☐ |

9 Is the patient currently undergoing any form of rehabilitation?

☐ Yes ☐ No

If ''Yes'', please provide the details of rehabilitation:

_____

_____

10 What is the prognosis of the patient's neurological impairments?
(You may tick more than one box.)

☐ Recovered
☐ Stable and improving
☐ No change
☐ Progressively worsening
☐ Permanent

Remarks: _____

_____

_____

11 Is there continuous improvement in the patient's condition?

☐ Yes ☐ No

Remarks: _____

_____

_____

## Part E : Patient's Medical Information - This section is COMPULSORY to be completed for all Critical Illnesses

1. Please provide the name and address of all doctors, specialists, or hospitals to which the patient has been referred or attended for this condition.

| Consultation date(s) | Name of Doctor | Name and Address of Clinic / Hospital |
|---|---|---|
| | | |
| | | |

2. (a) Has the patient previously suffered from this disease or any related illness? ☐ Yes ☐ No

(b) If Yes, please state the dates of consultations, diagnosis, name of doctor, name of clinic / hospital and the treatments / medications given.

| Consultation Date(s) | Diagnosis | Name of Doctor | Name of Clinic / Hospital | Treatment / Medication(s) Given |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

3. In your opinion, is there any further information that will assist us in assessing the claim. If Yes, please furnish such information below.

I hereby certify that I have personally examined and treated the patient for the above injuries / illness. I hereby declare that all the answers and statements are complete and true to the best of my knowledge, belief and that I have withheld no material fact from the Company. I also hereby certify that the above information is correct as per records from the hospital / clinic.

| Signature of Attending Physician | Name & Qualification of Attending Physician | Official Stamp of Hospital |
|---|---|---|
| | | |
| **Date** | **Email Address** | **Telephone No** |
| D D M M Y Y Y Y | | |