ZURICH Takaful

Claim No. (For Office Use Only)										
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Confidential Medical Questionnaire – Organ-Specific Disorders and Dysfunction

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 Note: Please enclose copies of all laboratory reports including x-rays, CT scans, any other imaging studies, laboratory evidence, post-surgery report, renal biopsy, blood and laboratory test results (for SLE-blood test on antibodies), ultrasound/imaging study of kidney, haemodialysis with report, 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 Y Y

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

b What were the symptoms / complaints? _____

_____

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

Diagnosis

3 a Full and exact diagnosis _____

_____

b When was the illness FIRST diagnosed? D D M M Y Y Y Y

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

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

_____

4 a Details of investigations performed _____

_____

_____

b Date of investigations performed | D | D | M | M | Y | Y | Y | Y |

c Details of treatment rendered

_____

_____

_____

d Date of last consultation | D | D | M | M | Y | Y | Y | Y |

e 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 | Y | Y | ____ am/pm

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

d Name of surgery performed

_____

_____

e Date of surgery | D | D | M | M | Y | Y | 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 Mellitus				

d Any Other Illness or Disability, please specify.

_____

_____

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

8 **Fulminant Viral Hepatitis**

a If the liver disease is caused by viral hepatitis, what is the type of virus involved? _____

_____

b Please describe the extent of the disease.
(i) Is the size of liver rapidly decreasing? ☐ Yes ☐ No

(ii) Is there necrosis of entire liver lobules? ☐ Yes ☐ No

(iii) Is there deterioration of liver function tests? ☐ Yes ☐ No

(iv) Is there deepening jaundice? ☐ Yes ☐ No

9 **End Stage Liver Failure**

a Has the liver failure reached the end stage? ☐ Yes ☐ No

b Is the liver disease associated with drug or alcohol misuse? ☐ Yes ☐ No

c Please describe the extent of the disease.

(i) Is there permanent jaundice? ☐ Yes ☐ No
(ii) Is there ascites? ☐ Yes ☐ No
(iii) Is there hepatic encephalopathy? ☐ Yes ☐ No
(iv) Is there portal hypertension? ☐ Yes ☐ No

d Is the encephalopathy a form of Wernicke's encephalopathy? ☐ Yes ☐ No

10 **End Stage Lung Disease**

a Has the lung disease reach end stage? ☐ Yes ☐ No

b What is the underlying cause leading to respiratory failure? _____

_____

_____

c Does the patient have dyspnea at rest? ☐ Yes ☐ No

d Is patient on continuous permanent oxygen therapy at present? ☐ Yes ☐ No

e Is there a permanent impairment of lung function with a consistent Forced Expiratory Volume (FEV) of less than one (1) liter during the first second? ☐ Yes ☐ No

f What is the lung function test result? _____

_____

g What is the baseline arterial blood gas analysis results? _____ mmHg

11 **Major Organ / Bone Marrow Transplant**

a Please provide full and exact details of the diagnosis leading to transplant surgery.

_____

_____

_____

b Which of the following organ is involved?

- ☐ Kidney
- ☐ Lung(s)
- ☐ Liver
- ☐ Heart
- ☐ Pancreas
- ☐ Small Bowel
- ☐ Bone Marrow
- ☐ Other organ, please specify: _____

c What is the condition/illness leading to the necessity of organ transplant?

_____

_____

d For human bone marrow, is it using hematopoietic stem cells?

☐ Yes ☐ No

e Has the patient undergone the transplant surgery as a recipient?

☐ Yes ☐ No

If "Yes", please give details of transplant surgery performed.

Date of Surgery	Type of Transplant	Doctor and Hospital Name

If "No", please state if the patient is on an official Malaysia waiting list as a recipient for a transplant? Please submit the official confirmation document:

_____

_____

_____

12 **Systemic Lupus Erythematosus (SLE) with Severe Kidney Complications**

a If the kidney disease is due to Systemic Lupus Erythematosus (SLE), please indicate the WHO classification of the Type of Lupus Nephritis as confirmed by renal biopsy.

- ☐ Type I - Minimal change glomerulonephritis
- ☐ Type II - Mesangial glomerulonephritis
- ☐ Type III - Focal Segmental glomerulonephritis
- ☐ Type IV - Diffuse glomerulonephritis
- ☐ Type V - Membranous glomerulonephritis

b Which of the following areas or organs are involved in SLE?

- ☐ Blood
- ☐ Skin
- ☐ Joints
- ☐ Lungs
- ☐ Kidneys
- ☐ Other organ, please specify: _____

c Does the patient have discoid lupus? ☐ Yes ☐ No

d Please select the clinical manifestations exhibited by the patient.

- ☐ Malar rash
- ☐ Photosensitivity
- ☐ Oral ulcers
- ☐ Arthritis
- ☐ Serositis
- ☐ Renal disorder
- ☐ Blood disorder, i.e. Leukopenia / Lymphopenia / Haemolytic anaemia / Thrombocytopenia
- ☐ Positive Anti-nuclear antibodies
- ☐ Positive L.E. cells
- ☐ Positive Anti-DNA
- ☐ Positive Ati-Sm (Smith IgG Auto-antibodies)
- ☐ Others, please specify: _____

e What is the stage of renal failure? _____

f Please provide the details below and enclose copies of the biopsy report and investigation reports.

(i) Date of Biopsy D D M M Y Y Y Y

(ii) Biopsy/Investigation Result _____

Note: Please enclose copies of all investigation performed, e.g. renal biopsy results, blood and laboratory test results (for SLE-blood test on antibodies), ultrasound /Imaging study of kidney, haemodialysis card, renal function test with electrolytes report, etc.

_____

_____

_____

_____

13 **Third Degree Burns**

a What were the cause of the burns?

_____

_____

_____

b Were the burns caused by accident? ☐ Yes ☐ No

If "Yes", please give details:

(i) Date of Accident occurred D D M M Y Y Y Y

(ii) Where did it occur?

_____

_____

(iii) How did it occur?

_____

_____

_____

c Were the burns self-inflicted? ☐ Yes ☐ No

If "Yes", please give details:

_____

_____

d What is the percentage of total body surface area burnt? _____

e What was the degree of burns?

☐ 1st degree
☐ 2nd degree
☐ 3rd degree

f If there were 3rd degree burns, what percentage of total body surface area had 3rd degree burns?

_____

g How long was the patient in hospital?

_____ days

h Was any skin graft done?

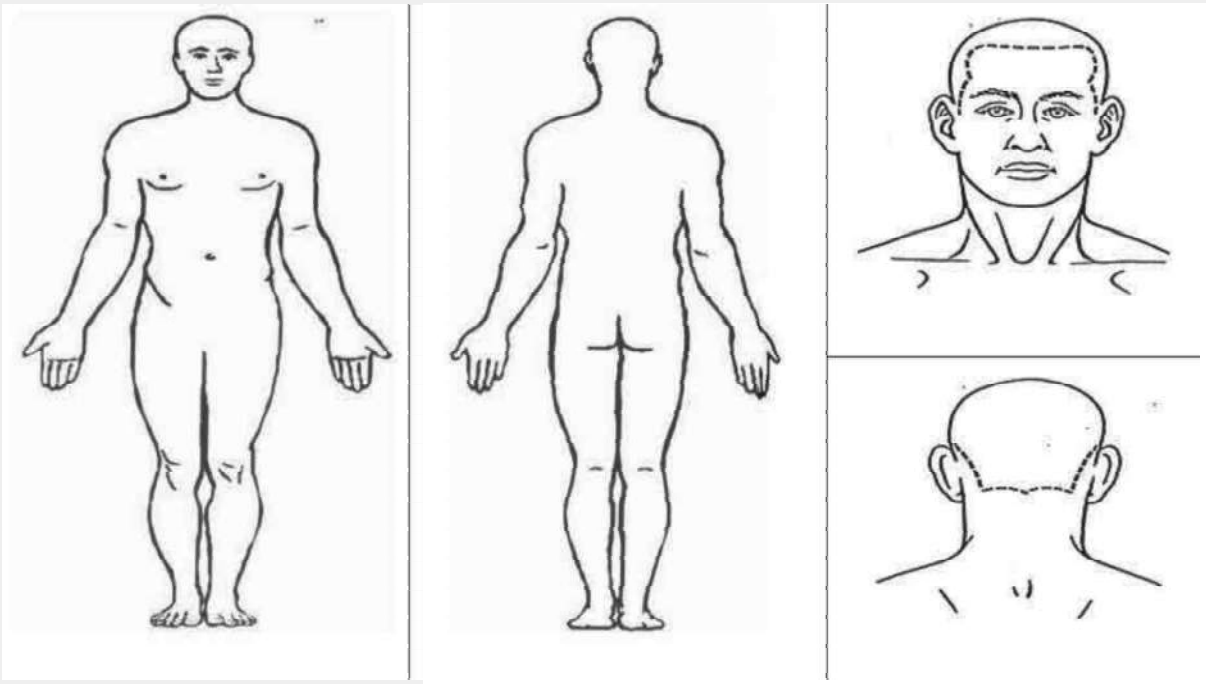
☐ Yes ☐ No

If "No", please give reason:

_____

i Please indicate on the Total Body Surface Area Burns Assessment figure below the areas that were burnt or attach a copy of the report from the medical record.

Please illustrate all the burnt areas and specify the areas with 3rd degree burns in the following diagrams.



14 **Blindness**

a What is the best corrected visual acuity of both eyes at present?
(i) Date of test performed

D	D	M	M	Y	Y	Y	Y

(ii) Name of test performed

_____

_____

(iii) Right eye

_____

(iv) Left eye

_____

b Please tick the relevant box for the severity of patient's visual acuity of both eyes at present.

(i) Right eye

☐ Normal
☐ Severe but not totally loss of sight
☐ Total and irrecoverable loss of sight
☐ None of the above, please specify: _____

(ii) Left eye

☐ Normal
☐ Severe but not totally loss of sight
☐ Total and irrecoverable loss of sight
☐ None of the above, please specify: _____

c Please confirm whether the patient is suffering from any of the following.

☐ Loss of sight – without perception of light
☐ Loss of sight – with perception of light
☐ None of the above, please specify: _____

d What are the underlying causes?

_____

_____

e What forms of treatment were rendered?

_____

_____

_____

f What is the prognosis?

_____

_____

g Will further surgery or other therapy improve patient's sight?

☐ Yes ☐ No

If "Yes", please give details (type of surgery, therapy, date, etc) of completed, current or planned treatment.

_____

_____

_____

h Is the loss of sight total and irreversible?

☐ Yes ☐ No

15 **Deafness**

a Was the diagnosis confirmed by an audiometric and sound-threshold test?

☐ Yes ☐ No

b What are the underlying causes?

_____

_____

c What is the prognosis?

_____

_____

_____

d Is the loss of hearing total and irreversible?

☐ Yes ☐ No

e What is the degree of hearing loss in all frequency of hearing using a pure tone audiogram or sound-threshold tests in both ears?

Right ear : _____ dB

Left ear : _____ dB

f Can it be reversible by hearing aid / surgical / other devices?

☐ Yes ☐ No

g If a hearing aid was not recommended, please give details as to why it was not recommended.

_____

_____

_____

h Has the patient previously suffered from any ear disease, exposure to noisy environment or any significant illness?

_____

_____

16 **Loss of Speech**

a How long is the duration of the loss of speech?

_____

b Is the loss of speech considered total and irreversible?

☐ Yes ☐ No

c What are the underlying causes?

_____

_____

d Is the loss of speech caused by injury or illness to the vocal cords?

☐ Yes ☐ No

If "Yes", please elaborate on the type of injury or illness and how does it result in loss of speech?

_____

_____

_____

e What is the prognosis?

_____

_____

_____

f Does the patient have any psychiatric disorders?

☐ Yes ☐ No

g Is the loss of speech related to the psychiatric disorder?

☐ Yes ☐ No

If "Yes", please give details:

_____

_____

_____

h Will further surgery or other therapy improve patient's loss of speech?

☐ Yes ☐ No

If "Yes", please give details (type of surgery, therapy, date, etc) of completed, current or planned treatment.

_____

_____

_____

Part D : 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		