هونغ ليونغ م. س. أ. ج. تكافل
HongLeong MSIG Takaful

Claim No.: ______________________

MEDICAL ATTENDANT'S REPORT ON DREAD DISEASE CLAIM

This report is to be completed by the registered medical practitioner at the own expense of Participant / Claimant.

In order for a claim under this Takaful Certificate condition to be paid, the following definition must be satisfied:

COMA

A state of unconsciousness with no reaction or response to external stimuli or internal needs, persisting continuously for at least ninety six (96) hours, requiring the use of life support systems and resulting in a neurological deficit, lasting more than thirty (30) days. Confirmation by a neurologist must be present.

Coma resulting directly from self-inflicted injury, alcohol or drug misuse is excluded.

Question	Answer
1. a) Name of Participant. b) I/C No. c) Date of Birth. d) Present Occupation. (If more than one, please state all) e) Takaful Certificate No.	a) b) c) d) e)
2. Please describe the exact details of your patient's present condition.	
3. a) When did your patient first consult you for this condition? b) Symptoms presented at that time. c) Date of symptoms first appeared.	a) b) c)
4. Had your patient suffered any previous episodes of this condition or any other conditions leading to it or relating to it? If so, please give details.	

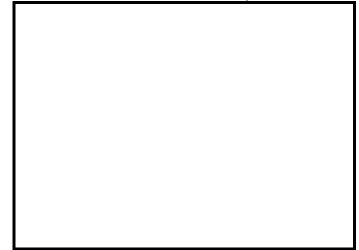
5. Are you aware of any members of your patient's close family who have suffered from the underlying cause of the coma?	
6. a) Was your patient referred to you? If so, please give name and address of doctor concerned. b) Name and address of doctor(s) who attended to your patient prior to seeing you. c) Name and address of doctor(s) concurrently treating your patient with you for this condition. d) Was your patient referred to any other doctor(s) by yourself? Please give name and address of the doctor(s).	a) b) c) d)
7. a) Please state date of diagnosis. b) Name and address of doctor who established the diagnosis. c) Was your patient informed of the diagnosis? If so, when and by whom?	a) b) c)
8. Have any other investigative tests or procedures been performed? If so, please give details.	

9. a) Does your patient have any Neurological Deficit? i) If "Yes" please elaborate further. ii) If "No", please elaborate further. b) Will the patient's Neurological Deficit be permanent in nature? i) If "Yes", please elaborate further. ii) If "No", please elaborate further.	a) i) ii) b) i) ii)
10. Please give details of your patient's smoking habits, both past and present. a) Does the patient smoke? i) If "Yes", how many sticks does the patient smoke in a day? ii) What is the exact duration? b) If "No", is the patient a non-smoker? c) If he was a smoker in the past, then when did the patient stop smoking?	a) i) ii) b) c)

11. Has the patient ever been diagnosed / suffered from any of the following:	Diagnosis	Date of Diagnosis / Onset	Name and Address of Doctor(s) Consulted	Dates of Treatment Consulted
a) Hypertension.	a)			
b) Diabetes Mellitus.	b)			
c) Cardiovascular Diseases.	c)			
d) Brain injury or brain disease.	d)			
e) Excessive narcotic or alcohol consumption.	e)			
f) Any habit forming drugs.	f)			
g) Have been treated for alcoholism or narcotic or drug habits.	g)			
h) Other illness(es) / Injuries.	h)			

We would be most grateful if you could send copies of any specialist or hospital reports, together with any tests, readings, or similar evidence to support the validity of your patient's claim.

Official Stamp:



Signature: ____

Name (in block capitals please): ___________________________________

Qualification: ____

Date: ____

For Office Use Only

Checked and Verified By: __________________________ Date: _____________ Branch: _____________
(Name of Staff)

12. Kindly fill up his / her record of the Glasgow Coma Scale as below:

Date	Time	Glasgow Coma Scale	Score
		Eye Response	
		Motor Response	
		Verbal Response	
		Total	
Date	**Time**	**Glasgow Coma Scale**	**Score**
		Eye Response	
		Motor Response	
		Verbal Response	
		Total	
Date	**Time**	**Glasgow Coma Scale**	**Score**
		Eye Response	
		Motor Response	
		Verbal Response	
		Total	
Date	**Time**	**Glasgow Coma Scale**	**Score**
		Eye Response	
		Motor Response	
		Verbal Response	
		Total	
Date	**Time**	**Glasgow Coma Scale**	**Score**
		Eye Response	
		Motor Response	
		Verbal Response	
		Total	
Date	**Time**	**Glasgow Coma Scale**	**Score**
		Eye Response	
		Motor Response	
		Verbal Response	
		Total	