هوڠ ليوڠ 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:

CHRONIC LUNG DISEASE

End stage respiratory failure including chronic interstitial lung disease.

The following criteria must be met:

i) Requiring permanent oxygen therapy as a result of consistent FEV one (1) test value of less than one (1) liter. (Forced Expiratory Volume during the first second of a forced exhalation);

ii) Arterial Blood Gas analysis with partial oxygen pressures of fifty five (55) mmHg or less; and

iii) Dyspnoea at rest.

1. a) Name of Participant.	a)
b) I/C No.	b) Old: New:
c) Date of Birth.	c)
d) Present Occupation. (If more than one, please state all)	d)
e) Takaful Certificate No.	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?	a)
b) Symptoms presented at that time.	b)
c) Date of symptoms first appeared.	c)

4. When did your patient first become aware of this condition?	
5. a) Please advice the frequency and severity of symptoms, and comment on how this restricts daily activities. b) Please provide details of all investigations carried out; particularly pulmonary function tests including dates and results. Please include current FEV 1 and vital capacity readings.	a) b)
6. What treatment is currently administered? If oxygen therapy is necessitated, please advice how frequently and where this is administered.	
7. a) Has the patient ever been exposed to any other substance that is likely to increase the risk of lung disease (whether through his / her occupation or not)? If yes, please give details. b) Is there anything in your patient's family history which may have increased the risk of lung disease?	a) b)
8. 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.	

9. Are you aware of any members of your patient's close family who have suffered from this or any similar conditions?	
10. 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)
11. Please confirm the diagnosis of chronic lung disease. Please give full details of investigations and results (including dates) i.e. lung function tests FEV, PEFR, bronchograms etc. Please state present treatment and medication.	
12. 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)

13. 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)
14. Has this patient ever been diagnoses / suffered from any of the following: a) Hypertension. b) Diabetes Mellitus. c) Cardiovascular Disease. d) Other Illness(es) / Injuries. If so, please provide the diagnosis, date of diagnosis / onset, names and addresses of all doctors consulted and dates of consultation.	 a) b) c) d)
15. Please give any other information which you feel would be helpful in the assessment of your patient's claim.	

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)