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:

HEART ATTACK

The death of a portion of heart muscle (myocardium) as a result of inadequate blood supply and being evidenced by:

i) A history of typical prolonged chest pain;
ii) New electrocardiographic changes resulting from this occurrence; and
iii) Elevation of the cardiac enzyme (CPK-MB) above the generally accepted laboratory levels of normal.

Diagnosis based on the elevation of Troponin T test alone shall not be considered diagnostic of a heart attack.

Angina is specifically excluded.

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) DD_____ MM_____ YY_____ b) c) DD_____ MM_____ YY_____
4. When did your patient first become aware of this condition?	DD_____ MM_____ YY_____

5. 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?	
	Consultation Dates Name and Address of Doctor(s)
6. a) Was your patient referred to you? If so, please give name and address of doctor concerned.	a) DD_____ MM_____ YY_____
b) Name and address of doctor(s) who attended to your patient prior to seeing you.	b)
c) Name and address of doctor(s) concurrently treating your patient with you for this condition.	c)
d) Was your patient referred to any other doctor(s) by yourself? Please give name and address of the doctor(s).	d)
7. Please complete the section below relating to your patient's condition.	
a) Did your patient suffer from a heart attack?	a)
b) Please give full details of any chest pain prior to the attack.	b)
c) Was an ECG performed? If so, please give date and details of the ECG changes. ***<u>Please enclose a copy of the ECG results</u>***.	c)
d) Were cardiac enzymes measured? If so, please give details of type and levels.	d) CPK-MB : ____________________ Troponin T : ____________________

Question	Answer
8. a) Please state date of diagnosis.	a) DD_____ MM_____ YY_____
b) Name and address of doctor who established the diagnosis.	b)
c) Was your patient informed of the diagnosis? If so, when and by whom?	c)
9. Have any other investigative tests or procedures been performed? If so, please give details.	
10. Please give details of your patient's smoking habits, both past and present.	
a) Does the patient smoke?	a)
i) If "Yes", how many sticks does the patient smoke in a day?	i)
ii) What is the exact duration?	ii) DD_____ MM_____ YY_____
b) If "No", is the patient a non-smoker?	b)
c) If he was a smoker in the past, then when did the patient stop smoking?	c) DD_____ MM_____ YY_____
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 Disease.	c)
d) Other Illness(es) / Injuries.	d)

If so, please provide diagnosis, date of diagnosis / onset, names and addresses of all doctors consulted and dates of consultation.	
12. 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)