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:

BRAIN SURGERY

The undergoing of surgery to the brain under general anesthesia during which the scalp is opened. Brain surgery due to accident is 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) Old: New: 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. When did your patient first become aware of this condition?	

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.	
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) Details of the exact surgical procedure. b) Did your patient undergo surgery of the brain? If yes, please give details. c) What was the indication for the surgery? d) Please give details of the operations procedure. e) Please state the final diagnosis.	a) b) c) d) e)

8. a) Please state date of diagnosis.	a)
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)
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)

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) Brain injury or brain disease.	d)			
e) Other illness(es) / Injuries.	e)			
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)