HongLeong MSIG Takaful

هوڠ ليوڠ م. س. أ. ج. تكافل

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:

BACTERIAL MENINGITIS

Bacterial meningitis causing inflammation of the membranes of the brain or spinal cord resulting in permanent neurological deficit, the diagnosis to be confirmed by a consultant neurologist.

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 symptoms first appeared.	a) b) c)
4. When did your patient first become aware of this condition?	

HLTMT/CL021(06/08)

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. Are you aware of any members of your patient's close family who have suffered from this or any similar conditions?	
7. a) Was your patient referred to you? If so, please give name and address of doctor concerned.	a)
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)

8. Please confirm the diagnosis of bacterial meningitis. a) Please give full details of any headaches, photophobia, and neck stiffness. b) Was there a positive kerning's sign? c) Was there any neurological deficit? If yes, please give details. d) Will the neurological deficit persist? e) Will the neurological deficit be permanent? f) Please give details of the diagnostic tests performed with results e.g. CSF testing.	a) b) c) d) e) f)
9. 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)
10. Have any other investigative tests or procedures been performed? If so, please give details.	

11. 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)
12. Has the patient ever been diagnosed / suffered from any of the following: a) Hypertension. b) Diabetes Mellitus. c) Cardiovascular Disease. d) Other Illness(es) / Injuries. If so, please provide diagnosis, date of diagnosis / onset, names and addresses of all doctors consulted and dates of consultation.	Diagnosis / Date of Diagnosis / Onset / Name and Address of Doctor(s) Consulted / Dates of Treatment Consulted a) b) c) d)
13. 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: ____

<u>For Office Use Only</u>

Checked and Verified By: ____________________ Date: ___________ Branch: ___________
(Name of Staff)