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:

MAJOR HEAD TRAUMA

Physical head injury causing significant permanent functional impairment lasting for a minimum period of three (3) months from the date of the trauma or injury. The resultant permanent functional impairment is to be verified by a consultant neurologist and duly occurred by the Company's Medical Officer and must result in an inability to perform at least three (3) of the following Activities of Daily Living (ADL) either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word 'Permanent' shall mean beyond the hope of recovery with current medical knowledge and technology.

The Activities of Daily Living (ADL) are:

i) Transfer
ii) Mobility
iii) Continence
iv) Dressing
v) Bathing / Washing
vi) Eating

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?	a)
b) What were the presenting symptoms?	b)
c) How long had the symptoms been presented?	c)
d) Diagnosis established	d)
e) Date of injury	e)
f) Please give details of circumstances leading to the injury.	f)
g) Was there any reason to suspect that there were contributory circumstances which led to the injury, e.g. Under the influence of alcohol, fits etc.?	g)
h) Had your patient previously suffered from any illnesses relating to the present condition? If yes, please state dates of consultations and resulting diagnosis.	h)
4. Had your patient refused any form of medical treatment, e.g. surgery which may have presented or to reduce the severity of the impairment? If yes, please give reason(s).	

	Consultation Dates Name and Address of Doctor(s)
5. 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)
6. Please confirm the diagnosis. a) Was a skull fracture, brain damage or cerebral contusion evident? Please give details.	a)
b) Was a brain CT Scan or MRI scan performed? If so, please give details.	b)
c) Was there permanent neurological deficit causing significant functional impairment? If so, what was the duration? Please give dates.	c)
d) Was it likely to be permanent?	d)
e) Please describe any sequelae.	e)

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. Please grade your patient's ability to perform the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons, as behind:

1	Complete functional limitation in performing the ADL as described.
2	Substantial limitation in performing the ADL as described.
3	Minor limitation in performing the ADL. Assistance required on an intermittent basis or with some minor part of the activity or able to perform the ADL with the use of an aid or appliance.
4	No functional limitation. Is able to perform the ADL independently.

The Activities of Daily Living (ADL) are:
Please tick the relevant box.

a) Transfer Getting in and out of a chair without requiring physical assistance.	a)	1	2	3	4
b) Mobility The ability to move from room to room without requiring any physical assistance.	b)	1	2	3	4
c) Continence The ability to voluntarily control bowel and bladder functions as to maintain personal hygiene.	c)	1	2	3	4
d) Dressing Putting on and taking off all necessary items of clothing without requiring the assistance of another person.	d)	1	2	3	4
e) Toileting Getting to and from the toilet, transferring on and off the toilet and associated personal hygiene.	e)	1	2	3	4
f) Eating All tasks of getting food into the body once it has been prepared.	f)	1	2	3	4

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 Disease.	c)			
d) Other Illness(es) / Injuries.	d)			
If so, please provide the 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: _____

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