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 a 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:

ALZHEIMER'S DISEASE

Deterioration or loss of intellectual capacity or abnormal behaviour as evidenced by the clinical state and accepted standardized questionnaire or tests arising from Alzheimer's Disease or irreversible organic degenerative brain disorders, excluding neurosis, psychiatric illness and any drug or alcohol related organic disorder, resulting in significant reduction in mental and social functioning requiring the continuous supervision of the Participant.

The diagnosis must be clinically confirmed by an appropriate consultant.

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) 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. 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. 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).	Consultation Dates Name and Address of Doctor(s) a) b) c) d)
8. 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)
9. Have any other investigative tests or procedures been performed? If so, please give details.	

10. 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

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:	Diagnosis	Date of Diagnosis / Onset	Name and Address of Doctors Consulted	Date of Treatment Consulted
a) Hypertension.	a)			
b) Diabetes Mellitus.	b)			
c) Cardiovascular Disease.	c)			
d) Excessive narcotic or alcohol consumption.	d)			
e) Any habit forming drugs.	e)			
f) Has been treated for alcoholism or narcotic or drug abuse.	f)			
g) Other illness(es) / Injuries.	g)			
If so, please provide diagnosis, date of onset / diagnosis, names and addresses of all doctors consulted and dates of consultation.				

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: _____

For Office Use Only

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