هوڠ ليوڠ م. س. أ. ج. تكافل

HongLeong MSIG Takaful

Claim No.: _____

## MEDICAL ATTENDANT'S REPORT ON DREAD DIEASE CLAIM

This report is to be completed by the registered medical practitioner at the expense of Participant / Claimant.

In order for a claim under this Takaful Certificate condition to be paid, the following definition must be satisfied:

**PRIMARY PULMONARY ARTERIAL HYPERTENSION**

Means primary pulmonary hypertension with substantial right ventricular enlargement established by investigations including cardiac catheterization, resulting in permanent irreversible physical impairment to the degree of at least Class three (3) of the New York Heart association Classification of cardiac impairment, and resulting in the Participant being unable to perform his / her usual occupation.

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| 1. a) Name of Participant.<br>b) I/C No.<br>c) Date of Birth.<br>d) Present Occupation.<br>(If more than one, please state all)<br>e) Takaful Certificate No. | a)<br>b) Old: New:<br>c)<br>d)<br>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?<br>b) Symptoms presented at that time.<br>c) Date of symptoms first appeared. | a)<br>b)<br>c) |
| 4. When did your patient first become aware of this condition? | |

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| 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. Was the disease associated with any underlying causes and conditions, or related to any congenital condition? | |
| 7. Are you aware of any members of your patient's close family who have suffered from this or any similar conditions? | |
| 8. a) Was your patient referred to you? If so, please give name and address of doctor concerned.<br><br>b) Name and address of doctor(s) who attended to your patient prior to seeing you.<br><br>c) Name and address of doctor(s) concurrently treating your patient with you for this condition.<br><br>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)<br>a)<br><br>b)<br><br>c)<br><br>d) |

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| 9. Please give the results of any investigations performed e.g. Chest X-ray, ECG's enchocardiograph, cardiac catheterization and any other tests performed.<br><br>What treatment has been, and is currently being administered? Has transplantation been considered? | |
| 10 . What was the extent of the pulmonary arterial hypertension? | |
| a) Was there dyspnoea and fatigue? | a) Yes ☐ No ☐ |
| b) Was there increase left atrial pressure of at least 20 units or more? | b) Yes ☐ No ☐ |
| c) Was there pulmonary resistance of at least 3 units above normal? | c) Yes ☐ No ☐ |
| d) Was there pulmonary artery pressure of at least 40mm Hg? | d) Yes ☐ No ☐ |
| e) Was there pulmonary wedge pressure of at least 60mm Hg? | e) Yes ☐ No ☐ |
| f) Was there right ventricular end-diastolic pressure least 8mm Hg? | f) Yes ☐ No ☐ |
| 11. 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) |

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| 12. Have any other investigative tests or procedures been performed? If so, please give details. | |
| 13. Please give details of your patient's smoking habits, both past and present.<br><br>a) Does the patient smoke?<br><br>i) If "Yes", how many sticks does the patient smoke in a day?<br><br>ii) What is the exact duration?<br><br>b) If "No", is the patient a non-smoker?<br><br>c) If he was a smoker in the past, then when did the patient stop smoking? | a)<br><br>i)<br><br>ii)<br><br>b)<br><br>c) |
| 14. Has the patient ever been diagnosed / suffered from any of the following:<br><br>a) Hypertension.<br><br>b) Diabetes Mellitus.<br><br>c) Cardiovascular Disease.<br><br>d) Other illness(es) / injuries.<br><br>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<br><br>a)<br><br>b)<br><br>c)<br><br>d) |
| 15. Has your patient taken drugs such as fenfluramine for weight reduction? | |
| 16. 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)