



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:

MEDULLARY CYSTIC DISEASE

A progressive hereditary disease of the kidney characterized by the presence of cysts in the medulla, tubular atrophy and interstitial fibrosis with the clinical manifestations of anemia, polyuria and renal loss of sodium, progressing to chronic renal failure. Diagnosis should be supported by renal biopsy.

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 symptoms first appeared.	a) b) c)

<p>4. When did your patient first become aware of this condition?</p>											
<p>5. Had your patient suffered any previous episodes of this condition or any conditions leading to it or relating to it? If so, please give details.</p>											
<p>6. a) Was your patient referred to you? If so, please give name and address of doctor concerned.</p> <p>b) Name and address of doctor(s) who attended to your patient prior to seeing you.</p> <p>c) Name and address of doctor(s) concurrently treating your patient with you for this condition.</p> <p>d) Was your patient referred to any other doctor(s) by yourself? Please give name and address of the doctor(s).</p>	<table border="1"> <thead> <tr> <th data-bbox="802 546 1023 577">Consultation Dates</th> <th data-bbox="1066 546 1426 577">Name and Address of Doctor(s)</th> </tr> </thead> <tbody> <tr> <td data-bbox="802 577 1023 734">a)</td> <td data-bbox="1066 577 1426 734"></td> </tr> <tr> <td data-bbox="802 734 1023 891">b)</td> <td data-bbox="1066 734 1426 891"></td> </tr> <tr> <td data-bbox="802 891 1023 1048">c)</td> <td data-bbox="1066 891 1426 1048"></td> </tr> <tr> <td data-bbox="802 1048 1023 1234">d)</td> <td data-bbox="1066 1048 1426 1234"></td> </tr> </tbody> </table>	Consultation Dates	Name and Address of Doctor(s)	a)		b)		c)		d)	
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d)											
<p>7. Please confirm the diagnosis of medullary cystic disease.</p> <p>a) Please give full details of any polyuria, polydipsia, growth retardation and renal failure.</p> <p>b) Please give full details of diagnostic tests performed and results e.g. renal biopsy / MRI / CT scan / Ultrasound.</p>											

<p>8. a) Please state date of diagnosis.</p> <p>b) Name and address of doctor who established the diagnosis.</p> <p>c) Was your patient informed of the diagnosis? If so, when and by whom?</p>	<p>a)</p> <p>b)</p> <p>c)</p>																				
<p>9. Have any other investigative tests or procedures been performed? If so, please give details.</p>																					
<p>10. Please give details of your patient's smoking habits, both past and present.</p> <p>a) Does the patient smoke?</p> <p> i) If "Yes", how many sticks does the patient smoke in a day?</p> <p> ii) What is the exact duration?</p> <p>b) If "No", is the patient a non-smoker?</p> <p>c) If he was a smoker in the past, then when did the patient stop smoking?</p>	<p>a)</p> <p> i)</p> <p> ii)</p> <p>b)</p> <p>c)</p>																				
<p>11. Has the patient ever been diagnosed / suffered from any of the following illnesses?</p> <p>a) Hypertension.</p> <p>b) Diabetes Mellitus.</p> <p>c) Cardiovascular Disease.</p> <p>d) Other Illness(es) / Injuries.</p>	<table border="1"> <thead> <tr> <th data-bbox="802 1339 911 1370">Diagnosis</th> <th data-bbox="938 1346 1046 1435">Date of Diagnosis / Onset</th> <th data-bbox="1078 1339 1214 1464">Name and Address of Doctor(s) Consulted</th> <th data-bbox="1302 1346 1417 1435">Dates of Treatment Consulted</th> </tr> </thead> <tbody> <tr> <td data-bbox="802 1480 825 1512">a)</td> <td></td> <td></td> <td></td> </tr> <tr> <td data-bbox="802 1615 825 1646">b)</td> <td></td> <td></td> <td></td> </tr> <tr> <td data-bbox="802 1749 825 1780">c)</td> <td></td> <td></td> <td></td> </tr> <tr> <td data-bbox="802 1883 825 1915">d)</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Diagnosis	Date of Diagnosis / Onset	Name and Address of Doctor(s) Consulted	Dates of Treatment Consulted	a)				b)				c)				d)			
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d)																					

<p>If so, please provide diagnosis, date of diagnosis / onset, names and addresses of all doctors consulted and dates of consultation.</p>	
<p>12. Please give any other information which you feel would be helpful in the assessment of your patient's claim.</p>	

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.

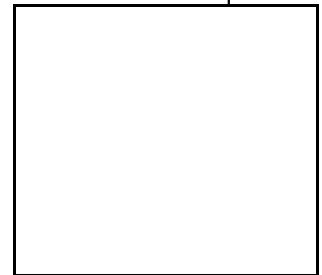
Signature: _____

Name (in block capitals please): _____

Qualification: _____

Date: _____

Official Stamp:



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