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 policy condition to be paid, the following definition must be satisfied:

OTHER SERIOUS CORONARY FOR CORONARY ARTERY DISEASE

The narrowing of the lumen of at least three major arteries i.e. Circumflex, Right Coronary Artery (RCA), Left Anterior Descending Artery (LAD), by a minimum of 60 percent or more as proven by coronary arteriography. This benefit is payable regardless of whether or not any form of coronary artery surgery has been performed.

i) Evidence of significant and relevant ECG changes (ST segment depression of 2 millimeters or more); and
ii) Angiographic evidence to confirm the location of stenosis.

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) DD_____ MM _____ YY_____ 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. d) In your professional opinion, how long would it take for the patient's condition to develop?	a) DD_____ MM _____ YY_____ b) c) DD_____ MM _____ YY_____ d)
4. When did your patient first become aware of this condition?	DD_____ MM _____ YY_____

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. 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)
7. Please complete the section below relating to the Treadmill / Stress E.C.G.	
a) What is the indication for Treadmill / Stress E.C.G.	a)
b) What was the patient's chief complaint?	b)
c) Date Treadmill / Stress E.C.G. was done.	c)
d) Name of doctor, clinic, hospital who did the Treadmill / Stress E.C.G.	d)
e) What is the exact ST Segment depression in millimetres?	e)
f) What is the interpretation of the Treadmill / Stress E.C.G.? Kindly enclose full copy of Treadmill E.C.G. Tracings.	f)

8. Please complete the section below relating to your patient's condition. a) What was the indication for the Coronary Angiogram?	a)
b) Full details of procedure or surgery performed.	b)
c) Number and location of lesions.	c)
d) Date of procedure / surgery.	d)
e) Could the coronary artery disease be adequately controlled by the medical therapy? If no, please elaborate further.	e)
9. Please give full details of coronary angiogram performed. Kindly enclose copy of the report.	

10. a) Please state date of diagnosis.	a) DD_____ MM_____ YY_____
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) DD_____ MM_____ YY_____
d) Please indicate the percentage (%) of narrowing for the following coronary arteries:	d)
i. Circumflex Artery :	i. _____ %
ii. Right Coronary Artery:	ii. _____ %
iii. Left Anterior Descending Artery	iii. _____ %
iv. Left Main Stem	iv. _____ %
11. Have any other investigative test or procedures been performed? If so, please give details of the result.	
12. Please give details of your patient's smoking habits, both past and present.	
a) Does the patient smoke?	a)
i) If "Yes", how many sticks does the patient smoke in a day?	i)
ii) What is the exact duration	ii)
b) If "No", is the patient a non-smoker?	b)
c) If he was a smoker in the past, then when did the patient stop smoking?	c)

13. Has the patient ever been diagnosed / suffered from any of the following:	YES NO Date Diagnosed
a) Hypertension.	a) YES:____ NO:____ DD____ MM____ YY_____
b) Diabetes Mellitus.	b) YES:____ NO:____ DD____ MM____ YY_____
c) Cardiovascular Disease.	c) YES:____ NO:____ DD____ MM____ YY_____
d) Excessive narcotic or alcohol consumption.	d) YES:____ NO:____ DD____ MM____ YY_____
e) High Blood Cholesterol (i.e.: hyperlipidemia, high blood lipids, and hyperlipoproteinemia)	e) YES:____ NO:____ DD____ MM____ YY_____
f) Has been treated for alcoholism or narcotic or drug abuse.	f) YES:____ NO:____ DD____ MM____ YY_____
g) Other illness(es) / Injuries.	g) YES:____ NO:____ DD____ MM____ YY_____
If so, please provide diagnosis, date of diagnosis / onset, names and addresses of all doctors consulted and dates of consultation.	
14. 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)