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:

FULMINANT VIRAL HEPATITIS

This is defined as a sub massive to massive necrosis of the liver caused by any virus leading precipitously to liver failure

The diagnostic criteria to be met are:
i) A rapidly decreasing liver size as confirmed by abdominal ultrasound;
ii) Necrosis involving entire lobules, leaving only a collapsed reticular framework;
iii) Rapidly deteriorating liver functions tests; and
iv) Deepening jaundice.

Hepatitis B infection or carrier status alone does not meet the diagnostic criteria.

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. Please confirm the diagnosis of Fulminant Viral Hepatitis. a) Please provide full and exact details of the diagnosis including the type(s) of viral involved, any objective signs of encephalopathy, hepatic insufficiency, deepening jaundice or any other symptoms.	a)

b) Please comment on the following:	b)
i) The state of the liver and its lobular architecture. Is the liver size rapidly decreasing?	i)
ii) The extent of the liver necrosis and the hepatocellular damage.	ii)
iii) The degree of impairment to the liver function. Does it constitute a parenchymal disease of the liver?	iii)
iv) When did the first symptoms of jaundice appear, and what are the details of the current severity?	iv)
v) The state of the liver and its lobular architecture. Is the liver size rapidly decreasing?	v)
vi) The extent of the liver necrosis and the hepatocellular damage.	vi)
vii) The degree of impairment to the liver function. Does it constitute a parenchymal disease of the liver?	vii)
viii) When did the first symptoms of jaundice appear, and what are the details of the current severity?	viii)
9. 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)

10. Please enclose lab reports / histopathology reports. Have any other investigatory tests or procedures e.g. Liver Function Tests, Biopsy of the Liver etc. been performed? If so, please give details.	
11. Was the liver failure a result of attempted suicide, poisoning, drug overdose or excessive alcohol ingestion? If yes, please give details.	
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. 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)

14. Has the patient ever been diagnosed / suffered from any of the following:	Diagnosis	Date of Diagnosis Onset	Name and Address of Of Doctor(s) Consulted	Date(s) 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 drug.	e)			
f) Have been treated for alcoholism or narcotic or drug habits.	f)			
g) Other illness(es) / Injuries.	g)			
If so, please provide the diagnosis, date of diagnosis / onset, names and addresses of all doctors consulted and dates of consultation.				
15. 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)