



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:

MUSCULAR DYSTROPHY

The definite diagnosis of a Muscular Dystrophy by a neurologist which must be supported by all of the following:

- Clinical presentation of progressive muscle weakness;
- No central/ peripheral nerve involvement as evidenced by absence of sensory disturbance;
- Characteristic electromyogram and muscle biopsy findings.

No Benefit will be payable under this Critical Event before the Person Covered has reached the age of twelve (12) years, next birthday.

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)

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).	<table border="1"> <thead> <tr> <th data-bbox="812 902 1023 931">Consultation Dates</th> <th data-bbox="1066 902 1428 931">Name and Address of Doctor(s)</th> </tr> </thead> <tbody> <tr> <td data-bbox="812 931 831 963">a)</td> <td></td> </tr> <tr> <td data-bbox="812 1133 831 1164">b)</td> <td></td> </tr> <tr> <td data-bbox="812 1335 831 1366">c)</td> <td></td> </tr> <tr> <td data-bbox="812 1536 831 1568">d)</td> <td></td> </tr> </tbody> </table>	Consultation Dates	Name and Address of Doctor(s)	a)		b)		c)		d)	
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<p>8. Please complete the section below relating to your patient's condition.</p> <p>a) Please advise the name and address of the neurologist who has confirmed the diagnosis of muscular dystrophy.</p> <p>b) What type of muscular dystrophy your patient been diagnosed?</p> <p>c) General examination findings:</p> <p>(i) Are there any abnormal movements or abnormal gait?</p> <p>(ii) Is there any muscle wasting or any signs of progressive muscle weakness impairment?</p> <p>(iii) Are there any sensory disturbances or any other significant examination findings?</p>	<p>a)</p> <p>b) <input type="checkbox"/> Duchenne's <input type="checkbox"/> Myotonic <input type="checkbox"/> Facioscapulohumeral <input type="checkbox"/> Congenital <input type="checkbox"/> Others: _____</p> <p>(i) <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", please give details. _____</p> <p>(ii) <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", please give details. _____</p> <p>(iii) <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", please give details. _____</p>
<p>9. 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>10. Have any other investigative tests or procedures been performed? If so, please give details.</p>	

<p>11. 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>12. Has the patient ever been diagnose / suffered from any of the following:</p> <p>a) Hypertension.</p> <p>b) Diabetes Mellitus.</p> <p>c) Cardiovascular Disease.</p> <p>d) Other Illness(es) / Injuries.</p> <p>If so, please provide diagnosis, date of diagnosis / onset, names and addresses of all doctors consulted and dates of consultation.</p>	<table border="1"> <thead> <tr> <th data-bbox="812 698 927 730">Diagnosis</th> <th data-bbox="948 698 1054 797">Date of Diagnosis / Onset</th> <th data-bbox="1086 698 1222 831">Name and Address of Doctor(s) Consulted</th> <th data-bbox="1289 698 1406 797">Dates of Treatment Consulted</th> </tr> </thead> <tbody> <tr> <td data-bbox="812 837 831 869">a)</td> <td></td> <td></td> <td></td> </tr> <tr> <td data-bbox="812 969 831 1001">b)</td> <td></td> <td></td> <td></td> </tr> <tr> <td data-bbox="812 1102 831 1133">c)</td> <td></td> <td></td> <td></td> </tr> <tr> <td data-bbox="812 1234 831 1265">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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<p>13. 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.

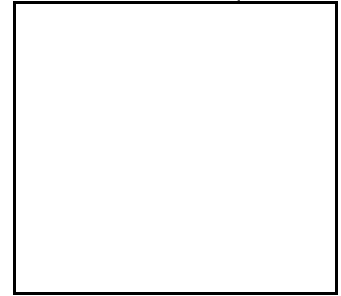
Official Stamp:

Signature: _____

Name (in block capitals please): _____

Qualification: _____

Date: _____



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