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:

**MUSCULAR DYSTROPHY**

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

a) Clinical presentation of progressive muscle weakness;
b) No central/ peripheral nerve involvement as evidenced by absence of sensory disturbance;
c) 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.

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| 1. a) Name of Participant. | a) |
| b) I/C No. | b) Old: New: |
| c) Date of Birth. | c) |
| d) Present Occupation. (If more than one, please state all) | d) |
| e) Takaful Certificate No. | 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? | a) |
| b) Symptoms presented at that time. | b) |
| c) Date symptoms first appeared. | c) |

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| 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.<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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| 8. Please complete the section below relating to your patient's condition. | |
| a) Please advise the name and address of the neurologist who has confirmed the diagnosis of muscular dystrophy. | a) |
| b) What type of muscular dystrophy your patient been diagnosed? | b) ☐ Duchenne's<br>☐ Myotonic<br>☐ Facioscapulohumeral<br>☐ Congenital<br>☐ Others: _____ |
| c) General examination findings:<br>(i) Are there any abnormal movements or abnormal gait? | (i) ☐ Yes ☐ No<br>If "YES", please give details.<br>_____ |
| (ii) Is there any muscle wasting or any signs of progressive muscle weakness impairment? | (ii) ☐ Yes ☐ No<br>If "YES", please give details.<br>_____ |
| (iii) Are they any sensory disturbances or any other significant examination findings? | (iii) ☐ Yes ☐ No<br>If "YES", please give details.<br>_____ |
| 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. Have any other investigative tests or procedures been performed? If so, please give details. | |

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| 11. 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) |

| 12. Has the patient ever been diagnose / suffered from any of the following: | Diagnosis | Date of Diagnosis / Onset | Name and Address of Doctor(s) Consulted | Dates of Treatment Consulted |
|---|---|---|---|---|
| a) Hypertension. | a) | | | |
| b) Diabetes Mellitus. | b) | | | |
| c) Cardiovascular Disease. | c) | | | |
| d) Other Illness(es) / Injuries. | d) | | | |
| If so, please provide diagnosis, date of diagnosis / onset, names and addresses of all doctors consulted and dates of consultation. | | | | |

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| 13. 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)