

CRITICAL ILLNESS CLAIM - DOCTOR'S STATEMENT

Other Illnesses

Note: This form is to be completed at the Patient's expense by the Attending Physician/ Surgeon.



Patient's Personal Details

Name <input style="width:90%" type="text"/>		Policy Number <input style="width:80%" type="text"/>
NRIC/Old IC/Passport/Birth Cert/Others <input style="width:90%" type="text"/>	Date of Birth <input style="width:80%" type="text"/>	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

The claim is being filed for the following illness: (Please tick [✓] in the appropriate box)

Sections to be completed		Sections to be completed	
<input type="checkbox"/> AIDS due to blood transfusion/ HIV Due to Blood Transfusion	A, B, M & N	<input type="checkbox"/> Type 2 Diabetic Retinopathy	A, H, M & N
<input type="checkbox"/> Full Blown AIDS	A, C, M & N	<input type="checkbox"/> Limb Amputation due to Type 2 Diabetic Complications	A, I, M & N
<input type="checkbox"/> Aplastic Anaemia / Chronic Aplastic Anaemia	A, D, M & N	<input type="checkbox"/> Major Organ Transplant or Bone Marrow Transplant	A, J, M & N
<input type="checkbox"/> Loss of Independent Existence	A, E, M & N	<input type="checkbox"/> Pending Major Organ Transplant	A, J, M & N
<input type="checkbox"/> Loss of Speech	A, F, M & N	<input type="checkbox"/> Small Bowel Transplant	A, K, M & N
<input type="checkbox"/> Facial Reconstructive Surgery	A, G, M & N	<input type="checkbox"/> Terminal Illness	A, L, M & N

Note: Assessment of claims and provision of benefits will be based on the Policy mentioned in this form.

SECTION A : Medical Record of the Patient

1. Are you the patient's regular/ family doctor?
 YES NO
 If Yes, over what period do your records extend?
 Day Month Year

2. Date the patient first consulted you for this illness / injury.
 Day Month Year

3. The presenting signs and symptoms during the first consultation with you.

4. The date when the patient first noticed the presenting signs and symptoms.
 Day Month Year

5. In your opinion, how long have the presenting signs and symptoms lasted prior to the first consultation with you?
 Day Month Year

6. Please describe the full and exact diagnosis and treatment advice was given.

Diagnosis Date (DD/MM/YYYY)	Diagnosis	Treatment Advice

7. Date when the patient was informed of the diagnosis.
 Day Month Year

8. Which of the following factors are present? For factors which are present, please provide the date of onset.

i. Hypertension YES NO Day Month Year

ii. Diabetes Mellitus YES NO Day Month Year

iii. Hyperlipidemia YES NO Day Month Year

iv. Others, please specify
 Day Month Year

SECTION B ▪ AIDS due to blood transfusion / HIV Due to Blood Transfusion

1. How did the patient contract the HIV infection?

- i. Intravenous drug use YES NO
- ii. Sexual activity YES NO
- iii. Blood transfusion YES NO
- iv. Maternal-fetal transmission YES NO
- v. Occupational exposure YES NO
- vi. Others, please explain

If Yes, please specify if the patient is a homosexual or sexual worker.

2. Was a HIV antibody test done before the blood transfusion?

- YES NO

If Yes, what was the result and to provide copy of laboratory test results.

3. Why was the patient receiving blood transfusion?

- Part of a medical treatment Due to accident

Please provide details of the medical condition/ accident details.

4. Was the blood transfusion medically necessary or given part of treatment?

- YES NO

5. On what date and at which hospital did the blood transfusion take place?

Date (DD/MM/YYYY)	Hospital
<input type="text"/>	<input type="text"/>

6. Is the hospital institution able to trace the origin of the HIV tainted blood?

- YES NO

If Yes, please provide details of tainted blood.

7. Was a statement from a statutory Health Authority given confirming that the infection was acquired through blood transfusion?

- YES NO

If Yes, please provide a statement from Health Authority as evidence of proof of incident.

Please attach certified true copies of all relevant reports. (E.g. HIV or antibody test results prior to blood transfusion, HIV or antibody test results after blood transfusion, Statement from Health Authority on proof of incident, etc.)

SECTION C ▪ Full Blown AIDS

1. Is there a HIV antibody test or Western Blot test performed?

- YES NO

Please provide dates and results of all investigations done (including but not limited to HIV Ab, Western blot etc) to confirm the diagnosis of HIV/AIDS and attach copies of all relevant laboratory results.

2. At the time of diagnosis, what was the patient's CD4 cell count?

Does the patient have evidence of opportunistic infection and/or AIDS related tumours? If Yes, please provide details.

- YES NO

3. Please tick [✓] if the following conditions are present.

- Wasting Syndrome, please provide details of weight loss and the duration.
- Kaposi Sarcoma
- Pneumocystic Carinii Pneumonia
- Progressive Multifocal Leukoencephalopathy
- Active Tuberculosis
- Less than one-thousand (1000) lymphocytes
- Malignant Lymphoma
- Spouse and sexual partners of the above groups

Please attach certified true copies of all relevant reports (E.g. HIV (Human Immuno-deficiency Virus) antibody test, Confirmatory Western Blot test, Laboratory reports of CD4 cell count, Any Other investigation results and reports, etc.)

SECTION D ▪ Aplastic Anaemia / Chronic Aplastic Anaemia

1. Was the aplastic anemia acute or chronic in nature?

- Acute Chronic

2. Please state the underlying cause of the condition.

3. Was there a bone marrow biopsy to confirm the diagnosis? If Yes, please attach copy of biopsy report.

- YES NO

If No, please state the reason why Bone Marrow biopsy was not done.

4. At time of diagnosis, what was the haemoglobin level, red cell count, white cell count and platelet count?

- | | |
|---|--|
| i. Haemoglobin level <input style="width: 250px; height: 20px;" type="text"/> | iii. White cell count <input style="width: 250px; height: 20px;" type="text"/> |
| ii. Red cell count <input style="width: 250px; height: 20px;" type="text"/> | iv Platelet count <input style="width: 250px; height: 20px;" type="text"/> |

5. Please provide date of last consultation and the Full Blood Count level on last consultation.

Date of Last Consultation (DD/MM/YYYY)	Full Blood Count Level

6. Were the following treatment given?

Treatment		If Yes, please provide details
Regular blood product transfusion	<input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, please state frequency of transfusion and blood product transfused.
Marrow stimulating agents	<input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, please state the medications and dosage.
Immunosuppressive agents	<input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, please state the medications and dosage.
Bone marrow transplantation	<input type="checkbox"/> YES <input type="checkbox"/> NO	If Yes, please provide date of transplant and hospital/doctor involved.

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT scanning, Imaging reports, Surgery report or hospital reports, Blood and laboratory test results, etc.)

SECTION E**▪ Loss of Independent Existence**

1. Please describe the latest physical or mental impairment of the patient as of the last consultation with you.

Date of Last Consultation (DD/MM/YYYY)	Physical or Mental Impairment

2. Details of treatment rendered.

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3. Was there any surgery performed?

YES NO

If Yes, please provide details of surgical procedure and date performed.

Date of Surgery (DD/MM/YYYY)	Details of Surgical Procedure

4. If the patient is not bedridden, please indicate the activities of daily living (ADL) that the patient is NOT able to perform with or without the use of mechanical equipment, special devices or other aids and adaptations. Please tick [✓] the appropriate ADL.

- Transfer – Getting in and out of a chair without requiring physical assistance
- Mobility – Ability to move from room to room without requiring physical assistance
- Continence – Ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene
- Dressing - Putting on and taking off all necessary items of clothing without requiring assistance from another person
- Bathing/Washing – Ability to wash in the bath or shower (including getting in and out of the bath or shower) or wash by any other means
- Eating - All tasks of getting food into the body once it has been prepared

5. How long has such inability been documented (in months)?

months

6. Is such inability expected to be permanent?

YES NO

7. Is there any current medical treatment/surgery which could improve the patient's condition?

YES NO

If Yes, please provide details.

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8. What is the progress of recovery, if any?

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9. What is the prognosis?

Retrogressed Static Improving Recovered

Please attach copies of all the relevant reports of tests available (E.g. Radiological, CT scanning, Imaging reports, Surgery report or hospital reports, Blood and laboratory test results, etc.)

SECTION F**▪ Loss of Speech**

1. What is the underlying cause of the patient's inability to speak?

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2. Was the inability to speak related to the vocal cord?

YES NO

If Yes, please provide medical evidence to confirm injury or illness to vocal cords.

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3. Is the loss of speech

- i. Total YES NO
- ii. Permanent YES NO
- iii. Irrecoverable YES NO
- iv. Psychiatric Related YES NO

If Yes, please provide details

4. What was the duration of loss of speech?

- i. A continuous period of 6 months YES NO
- ii. A continuous period of 12 months YES NO
- iii. Others, please specify

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT scanning, Imaging reports, Surgery report or hospital reports, Blood and laboratory test results, Medical evidence to confirm injury or illness to the vocal cords to support this disability by an Ear, Nose, Throat Specialist (ENT))

SECTION G ▪ Facial Reconstructive Surgery

1. Was the condition caused by accident?

- YES NO

If Yes, please provide the following information.

- i. Date of Accident Day Month Year

- ii. Was police report lodged? YES NO If Yes, please provide a copy of the report.

- iii. Was there reason to suspect that there were contributory circumstances which led to the injury (E.g. under influence of alcohol, drugs, fits and etc)?

- YES NO

If Yes, please state such information.

- iv. Was the injury a result of a self-inflicted injury or mental illness?

- YES NO

If Yes, please provide details.

2. Please provide details of any facial disfigurement sustained and enclose copies of radiological/ imaging reports.

3. Was surgery performed?

- YES NO

If Yes, please provide the following information and enclose copy of hospitalization itemized bill.

Date of Surgery (DD/MM/YYYY)	Details of Surgical Procedure	Doctor Name & Address
<input type="text"/>	<input type="text"/>	<input type="text"/>

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT scanning, Imaging reports, Surgery report or hospital reports, Blood and laboratory test results, Police Report, etc.)

SECTION H ▪ Type 2 Diabetic Retinopathy

1. Type of Diabetes and type of Retinopathy.

- Diabetes Mellitus Type 1 Diabetes Mellitus Type 2

Type of Retinopathy

2. Please specify which of the eye is affected by Diabetic Retinopathy and to attach copies of the Fluorescent Fundus Angiography report or other diagnostic tests with reports/ result.

3. Does the patient require laser treatment or vitrectomy for his/her condition?

YES NO

4. Please state the type of treatment and date(s) of treatment and enclose detailed report.

Date of Treatment (DD/MM/YYYY)	Details & Type of Treatment

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT Scanning, Imaging reports, Blood and laboratory test results, Surgical reports and any relevant hospital reports, Diagnostic test results Police Report where relevant, Any clinical assessment report, etc.)

SECTION I ▪ Limb Amputation due to Type 2 Diabetic Complications

1. Please state the underlying cause for the condition. If the underlying cause is Diabetes Mellitus, please state type 1 or type II

2. Was surgery performed?

YES NO

If Yes, please provide details of the surgery and copies of operation report.

Date of Surgery (DD/MM/YYYY)	Details of Surgical Procedure	Doctor Name & Address

3. Was amputation done?

YES NO

If Yes, please state the site/ area of amputation.

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT Scanning, Imaging reports, Blood and laboratory test results, Surgical reports and any relevant hospital reports, Diagnostic test results Police Report where relevant, Any clinical assessment report, etc.)

SECTION J ▪ Major Organ Transplant or Bone Marrow Transplant ▪ Pending Major Organ Transplant

1. Please provide full and exact details of the diagnosis and disease leading to transplant surgery.

2. On what date did the patient become aware of the condition necessitating surgery?

Day Month Year

3. Which organ is involved (E.g. kidney, lung(s), liver, heart, pancreas, small bowel or bone marrow)?

4. What is the condition/ illness leading to the necessity of organ transplant?

5. For human bone marrow, is it using hematopoietic stem cells preceded by total bone marrow ablation?

YES NO

6. Has the patient undergone the transplant surgery as a recipient?

YES NO

If Yes, please provide details of transplant surgery performed.

Date of Surgery (DD/MM/YYYY)	Type of Transplant	Doctor & Hospital Name

If No, please state if the patient is on an official Malaysia waiting list as a recipient for a transplant? Please submit the official confirmation document:

7. What is the prognosis?

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Surgical Report for Major Organ Transplantation, etc.)

SECTION K ▪ Small Bowel Transplant

1. For small bowel transplant, please state the length of the small bowel transplanted.

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2. Has the patient undergone the transplant surgery as a recipient?

YES NO

If Yes, please provide details of transplant surgery performed.

Date of Surgery (DD/MM/YYYY)	Type of Transplant	Doctor & Hospital Name

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Surgical Report for Major Organ Transplantation, etc.)

SECTION L ▪ Terminal Illness

1. Please give details of symptoms and treatment during the last consultation.

Date of Last Consultation (DD/MM/YYYY)	Physical or Mental Impairment

2. Has active therapy now been rejected in favour of relief of symptoms?

YES NO

3. Can you confirm that the advent of death is highly probable within six months?

YES NO

If Yes, please elaborate.

4. In your opinion, what is the remaining life expectancy of the patient?

YES NO

If Yes, please elaborate.

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Surgical Report for Major Organ Transplantation, etc.)

SECTION M : Others Medical Information

1. Has the patient previously suffered from this illness or any related illness or any other illnesses?

YES NO

If Yes, please provide details as required below :

Date of Consultation (DD/MM/YYYY)	Illness/ Diagnosis	Types of Treatment Received/ Details of Hospitalisation	Investigation Result	Name of Doctor & Name of Hospital/ Medical or Healthcare Facilities

2. Was the patient referred to you?

YES NO

If Yes, please provide details below and enclose a copy of the referral letter (if any):

Name & Address of Referral Doctor

SECTION N : Attending Doctor's Declaration

I hereby certify that:

I am the patient's attending doctor and I have personally examined and treated the patient for the illnesses/ injuries sustained; OR

I have personally perused the patient's medical records;

and that the facts as stated above are all true to the best of my knowledge and information that I have perused.

Signature : Date :
 Name :
 Professional Qualification :
 MMC/ Registration Number :
 Name & Address of Hospital/ Clinic :
 Official Stamp of the Hospital/ Doctor :