CRITICAL ILLNESS CLAIM - DOCTOR'S STATEMENT

Brain and Nerve Related Conditions

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

PRUDENTIAL

Patient's Personal Details

Name

Policy Number

NRIC/Old IC/Passport/Birth Cert/Others

Date of Birth

Gender ☐ Male ☐ Female

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

	Sections to be completed
☐ Apallic Syndrome	A, B, N & O
☐ Akinetic Mutism / Locked In Syndrome	A, B, N & O
☐ Encephalitis (With Recovery)	A, C, N & O
☐ Meningitis (With Recovery/Reversible Neurological Deficits)	A, C, N & O
☐ Tuberculous Myelitis / Meningeal Tuberculosis	A, C, N & O
☐ Brain (Aneurysm) Surgery	A, D, N & O
☐ Surgical Removal Of Pituitary Tumour	A, D, N & O
☐ Insertion of Cerebral Shunt	A, D, N & O
☐ Insertion of Ventriculoperitoneal Shunt	A, D, N & O
☐ Endovascular Treatment of Cerebral AVM	A, D, N & O
☐ Craniotomy for Treatment of Aneurysm/ AVM	A, D, N & O
☐ Benign Brain Tumour	A, E, N & O
☐ Surgical Excision of a Spinal Meningioma	A, E, N & O
☐ Surgery for Drug Resistant (Severe) Epilepsy	A, F, N & O
☐ Major Head Trauma (Mild / Severe)	A, G, N & O
☐ Cervical Spinal Cord Injury (Accident)	A, G, N & O
☐ Head Trauma (Accident) Requiring Re-constructive Surgery / Open Craniotomy	A, G, N & O

	Sections to be completed
☐ Surgical Repair of Depressed Skull Fracture	A, G, N & O
☐ Motor Neuron Disease (Early / Severe)	A, H, N & O
☐ Peripheral Neuropathy	A, H, N & O
☐ Myasthenia Gravis (Less Severe / Severe)	A, H, N & O
☐ Spinal Cord Disease/Injury Cause Bowel & Bladder Dysfunction	A, H, N & O
☐ Multiple Sclerosis (Early / Severe)	A, I, N & O
☐ Guillain-Barre Syndrome	A, I, N & O
☐ Parkinson's Disease (Early / Moderate / Severe)	A, J, N & O
☐ Progressive Supranuclear Palsy (Early / Late)	A, J, N & O
☐ Diagnosis of Alzheimer's Disease or Dementia	A, K, N & O
☐ Alzheimer's Disease or Dementia (Moderate / Severe)	A, K, N & O
☐ Stroke	A, L, N & O
☐ Stroke Treatment By Carotid Angioplasty & Stent	A, L, N & O
☐ Carotid Artery Surgery	A, L, N & O
☐ Surgery For Subdural Haematoma Due To Accident	A, L, N & O
☐ Coma	A, M, N & O

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

CRITICAL ILLNESS CLAIM - DOCTOR'S STATEMENT

Brain and Nerve Related Conditions

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

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

			Day	Month	Year
i. Hypertension	☐ YES	☐ NO			
ii. Diabetes Mellitus	☐ YES	☐ NO			
iii. Hyperlipidemia	☐ YES	☐ NO			
iv. Others, please specify					

Year

SECTION B ▪ **Apallic Syndrome** ▪ **Akinetic Mutism** ▪ **Locked In Syndrome** ***(To be completed by the Neurologist)***

1. Please provide the name and address of the doctor who diagnosed the patient.

2. Please state the clinical manifestations exhibited by the patient and date on the last consultation.

Clinical Manifestations Exhibited	Date (DD/MM/YYYY)

3. Is there presence of universal necrosis of the brain cortex with the brainstem intact?

☐ YES ☐ NO

If Yes, please provide full details, including the neurological deficit.

4. Please provide details and enclose reports of any imaging tests done.

5. Is the condition associated with any underlying causes or conditions or related to any congenital or psychological condition(s)?

☐ YES ☐ NO

If Yes, please provide details.

6. How long has the condition been medically documented?

7. Has the condition persisted for at least one month since its onset?

☐ YES ☐ NO

If Yes, please state the duration for which it has persisted and supported with a copy(ies) of medical reports. (E.g. EEG)

8. What treatment has been and is currently being administered?

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, EEG, etc.)

SECTION C ▪ **Encephalitis (With Recovery)** ▪ **Meningitis (With Recovery/Reversible Neurological Deficits)** ▪ **Tuberculous Myelitis / Meningeal Tuberculosis**

1. What was the causative agent of the infection?

☐ Bacterial ☐ Virus ☐ Fungus ☐ Others, please specify

Please state the name of the pathogen(s).

2. Was lumbar puncture performed? If Yes, please submit the CSF investigation reports (including C&S).

☐ YES ☐ NO

FORM ID 11601124

3. Was there any significant neurological deficit?

☐ YES ☐ NO

If Yes, please provide details.

4. For how long was the neurological deficit noted? Please state the duration.

From ☐ Day ☐ Month ☐ Year To ☐ Day ☐ Month ☐ Year

a. Is such impairment expected to be permanent? ☐ YES ☐ NO

b. Is there hope of recovery with current medical knowledge and technology? ☐ YES ☐ NO

5. Is the patient HIV positive?

☐ YES ☐ NO

If Yes, please provide the date that the patient was first diagnosed of HIV positive.

☐ Day ☐ Month ☐ Year

6. Is the Encephalitis/ Meningitis a result of HIV infection?

☐ YES ☐ NO

If No, please elaborate.

7. Which of the following Activities of Daily Living (ADL) is the patient NOT able to perform? Please tick [✓] as appropriate.

☐ Transfer – Getting in and out of a chair without requiring physical assistance

☐ Mobility – Abillity to move from room to room without requiring physical assistance

☐ Continence – Ability to voluntarily control bowel and bladder functions such as to maiintain 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

8. Is the inability to perform the above ADL expected to be permanent?

☐ YES ☐ NO

9. Did the infection result in patient's hospitalization?

☐ YES ☐ NO

If Yes, please provide the following details and attach the discharge summary,

Admission Date (DD/MM/YYYY)	Discharge Date (DD/MM/YYYY)	Hospital

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 D

- **Brain (Aneurysm) Surgery**
- **Surgical Removal of Pituitary Tumour**
- **Insertion of Cerebral Shunt**
- **Insertion of Ventriculoperitoneal Shunt**
- **Endovascular Treatment of Cerebral AVM**
- **Craniotomy for Treatment of Aneurysm / AVM**

1. Did the patient undergo surgery of the brain?

☐ YES ☐ NO

If Yes, please provide details of surgery

Date of Surgery (DD/MM/YYYY)	Reason of the Surgery

2. Was there head trauma leading to the surgery?

☐ YES ☐ NO

If Yes, please provide details.

Prudential Assurance Malaysia Berhad 198301012262 (107655-U)
Level 20, Menara Prudential, Persiaran TRX Barat, 55188 Tun Razak Exchange, Kuala Lumpur, Malaysia.
P.O. Box 10025, 50700 Kuala Lumpur Tel (603) 2778 3888 www.prudential.com.my
Customer Service Tel (603) 2771 0228

3. Was a Cerebral Shunt implanted during the surgery?

☐ YES ☐ NO

If Yes, please provide reason for the shunt.

4. Which of the following surgical approach/ procedure was performed ?

i. Craniotomy	☐ YES	☐ NO
ii. Burr Hole	☐ YES	☐ NO
iii. Transphenoidal	☐ YES	☐ NO
iv. Endovascular Treatment	☐ YES	☐ NO
v. Other Minimal Invasive Procedure	☐ YES	☐ NO

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Biopsy/ Histopathology report, Surgery reports and/or hospital record, Craniotomy surgery report for Brain Surgery, Police Report for Major Head Trauma, etc.)

SECTION E ▪ Benign Tumour of The Brain/ Benign Brain Tumour ▪ Surgical Excision of a Spinal Meningioma

1. Where was the location of the tumour?

☐ Brain ☐ Spine

Please specify the exact location of the tumour.

2. What is the nature of the tumour?

☐ Benign ☐ Malignant

Please state the extent of the tumour lesion & stage (Please state the staging system used)

3. Was there any damage to the brain?

☐ YES ☐ NO

4. Is the presence of the underlying tumour confirmed by CT scan, MRI or other imaging studies?

☐ YES ☐ NO

If Yes, please enclose copies of all investigation performed ie biopsy results, cytology reports, CT scan, MR imaging, etc

5. Is the tumour life-threatening in nature ?

☐ YES ☐ NO

If Yes, please elaborate.

6. Are there characteristic signs of intra-cranial pressure ?

☐ YES ☐ NO

If Yes, Were the below symptoms/ signs present?

i. Papilloedema	☐ YES	☐ NO	iv. Sensory Impairment	☐ YES	☐ NO
ii. Any mental symptoms	☐ YES	☐ NO	v. Others, to specify		
iii. Seizures	☐ YES	☐ NO			

7. Was the neurological deficit permanent with persisting clinical symptoms ?

☐ YES ☐ NO

If Yes, please provide details.

8. Has the tumour been surgically removed either totally or partially ?

☐ YES ☐ NO

If Yes, please answer the following questions,

A. Which of the following surgical approach/procedure was performed for removal of the tumour?
(Please select [✓] the applicable option)

i. Craniotomy	☐	
ii. Burr Hole	☐	
iii. Transphenoidal / Transnasal Hypophysectomy	☐	
iv. Other minimally invasive procedure	☐	Please specify,

B. *Please provide the surgery date, hospital in which it was performed and details of the histology findings.*

Date of Surgery (DD/MM/YYYY)	Hospital	Details of Histology

9. Is the diagnosis falling within any of the following conditions?

i. Cysts	☐ YES	☐ NO
ii. Granulomas	☐ YES	☐ NO
iii. Malformations in or of the arteries or veins of the brain	☐ YES	☐ NO
iv. Haematomas	☐ YES	☐ NO
v. Tumours of the pituitary gland	☐ YES	☐ NO
vi. Tumours of the spine	☐ YES	☐ NO
vii. Tumours of the acoustic nerve	☐ YES	☐ NO
viii. Tumours of the meninges	☐ YES	☐ NO

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Biopsy/ Histopathology report, Surgery reports and/or hospital record, Craniotomy surgery report for Brain Surgery, Police Report for Major Head Trauma, etc.)

SECTION F ▪ Surgery for Drug Resistant (Severe) Epilepsy

1. What was the type of Epilepsy?

☐ Grand Mal/ Tonic Clonic Seizure ☐ Petit Mal/ Absence Seizure

☐ Febrile Convulsion ☐ Others. Please specify

2. Was there any diagnostic test(s) done to confirm the diagnosis?

☐ YES ☐ NO

If YES, please provide the following details,

Date (DD/MM/YYYY)	Name of test(s)	Results

3. Please provide details of the consultation for the past 2 years, including presentation of the epilepsy and medication prescribed.

Consultation Date (DD/MM/YYYY)	Presenting Symptoms	Treatment and Medications	Period of prescription

4. Could the epilepsy be controlled by oral medication?

☐ YES ☐ NO

If NO, please elaborate and attach the drug-serum level test result,

5. Was there any surgery performed to the brain tissue for the patient's Epileptic condition?

☐ YES ☐ NO

If Yes, please provide details of the surgery.

Date of Surgery (DD/MM/YYYY)	Type of Surgery

Please attach copies of all the relevant reports of tests available. (I.e. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Biopsy/ Histopathology report, Surgery reports and/or hospital record, Craniotomy surgery report for Brain Surgery, Police Report for Major Head Trauma, etc.)

SECTION G

- **Head Trauma (Accident) Requiring re-constructive surgery / Open Craniotomy**
- **Surgical Repair of Depressed Skull Fracture**
- **Major Head Trauma (Mild / Severe)**
- **Cervical Spinal Cord Injury (Accident)**

(To be completed by the Neurologist)

1. Please select (✓) the applicable option(s) for the extent of the injury,

☐ Head ☐ Neck

Please provide the exact nature of the injury and enclose report(s) of the imaging done (E.g. MRI, CT scan)

2. Was there any fracture of the skull bones ? If Yes, please provide details and attach copy of radiological evidence.

☐ YES ☐ NO

3. What was the date of injury?

☐ Day ☐ Month ☐ Year

4. Please provide details of circumstance where the leading to injury.

5. Was surgery performed?

☐ YES ☐ NO

If Yes, please select the surgical approach done and the details of the surgery

Date of Surgery (DD/MM/YYYY)	Surgical Approach	Type of Surgery
	i. Craniotomy ☐ ii. Burr Hole ☐ iii. Other Minimally Invasive Procedure ☐ Please state,	

6. Please provide details of functional impairment and how long the impairment has lasted from date of trauma or injury.

Impairment	Duration (in months)

7. Is such impairment expected to be permanent?

☐ YES ☐ NO

8. Is there hope of recovery with current medical knowledge and technology?

☐ YES ☐ NO

9. What is the prognosis?

10. Kindly describe in detail the disability suffered by the patient that has rendered him permanently disabled when he was last seen by you.

11. Is the patient permanently bedridden as a result of the head trauma?

☐ YES ☐ NO

12. If the patient is not bedridden, please indicate the activities of daily living (ADL) that the patient is not able to perform. Please tick [✓] the appropriate ADL.

- ☐ Transfer – Getting in and out of a chair without requiring physical assistance
- ☐ Mobility – Abillity to move from room to room without requiring physical assistance
- ☐ Continence – Ability to voluntarily control bowel and bladder functions such as to maiintain 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

Please attach copies of all the relevant reports of tests available. (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Biopsy/ Histopathology report, Surgery reports and/or hospital record, Craniotomy surgery report for Brain Surgery, Police Report for Major Head Trauma, etc.)

SECTION H

- **Myasthenia Gravis**
- **Spinal Cord Disease Or Injury Resulting In Bowel And Bladder Dysfunction**
- **Motor Neuron Disease (Early / Severe)**
- **Peripheral Neuropathy**

(To be completed by the Neurologist)

1. Please select (√) relevant option from each column that is applicable to the patient's condition.

Type of Neuropathy	The specific disorder/causes of the neuropathy
☐ Central Neuropathy *Please state the impacted area(s) in the nervous system* _____	☐ Spinal Muscular Atrophy ☐ Progressive Bulbar Palsy ☐ Amyotrophic Lateral Sclerosis ☐ Primary Lateral Sclerosis
☐ Peripheral Neuropathy *Please state the impacted area(s) in the nervous system* _____	☐ Diabetes Mellitus ☐ Alcohol ☐ Infection ☐ Tumours ☐ Accident ☐ Autoimmune (Please specify) ☐ Others Please specify) _____

2. Please provide details of, including the date(s) of the extent of the neurological deficits and clinical signs according to your consultation record(s).

Dates (DD/MM/YYYY)	Clinical signs / Neurological Deficit
	1. Sensory
	2. Motor
	3. Autonomic

3. Please select (√) the relevant stage of the patient's current condition according to the **Myasthenia Gravis Foundation of America Clinical Classification**, *(Please answer this question **ONLY** for Myasthenia Gravis claim)*

☐ Class 1 : Any eye muscle weakness, possible ptosis, NO other evidence of muscle weakness elsewhere
☐ Class 2 : Eye muscle weakness of any severity, MILD weakness of other muscles
☐ Class 3 : Eye muscle weakness of any severity, MODERATE weakness of other muscles
☐ Class 4 : Eye muscle weakness of any severity, SEVERE weakness of other muscles
☐ Class 5 : Intubation needed to maintain airway

4. Are the above neurological deficits likely to be permanent?

☐ YES ☐ NO

If yes, please elaborate and state how long has the neurological deficits present.

5. What treatment and/or medications has been and is currently being administered?

6. Does the patient have or ever had any other significant health condition?

☐ YES ☐ NO

If Yes, please provide details of the condition, including diagnosis, date of diagnosis and treatment received.

7. Are you aware of any blood relative suffering from similar or related illness?

☐ YES ☐ NO

If Yes, please state the relationship, nature of illness and the date the illness was first diagnosed, if known.

Please provide copies of all investigation reports. (E.g. electromyography, biopsy, nerve conduction studies, MRI, CSF study, etc) and all relevant reports (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Surgery reports or hospital records, etc.)

SECTION I ▪ **Multiple Sclerosis (Early / Late)** ▪ **Guillain-Barre Syndrome** ***(To be completed by the Neurologist)***

1. Please select (√) the impacted nervous system and the autoimmune disease.

☐ Central Nervous System

☐ Peripheral Nervous System

2. Was there impairment of co-ordination and motor sensory function?

☐ YES ☐ NO

If Yes, how long has the symptoms lasted and please provide details.

3. Please provide details of consultation dates and extent of the patient's neurological deficit.

Date (DD/MM/YYYY)	Extent Neurological Deficit

4. Is there a history of exacerbations and remissions of neurological signs?

☐ YES ☐ NO

If Yes, please provide details including dates of each

5. Has the neurological signs led to hospital admissions?

☐ YES ☐ NO

If Yes, please provide the following details.

I. Reason for the admission(s);

II. Has there been severe respiratory failure attack for which the patient was placed with continuous endotracheal ventilation in ICU?

☐ YES ☐ NO

Period of having the artificial ventilation placed: _____ days / hours

III. Please state the treatment given during the admission(s)

6. Was there evidence of multiplicity or discrete lesions on imaging studies? If Yes, please provide copies of reports.

☐ YES ☐ NO

7. Please provide details of any confirmatory investigations performed.

8. Is the patient confined to a wheelchair?

☐ YES ☐ NO

If Yes, for how long? _____ Day _____ Month _____ Year

Please provide copies of all relevant reports. (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Surgery reports or hospital records, etc.)

SECTION J ▪ **Parkinson's Disease (Early / Moderate / Severe)** ▪ **Progressive Supranuclear Palsy (Early / Late)** ***(To be completed by the Neurologist)***

1. What was the underlying cause of the disease?

i. Idiopathic	☐ YES		☐ NO	
ii. Autoimmune	☐ YES		☐ NO	
iii. Drug-induced, please specify the drug	☐ YES		☐ NO	
iv. Toxins, please give details	☐ YES		☐ NO	

2. Was there permanent clinical impairment of motor function associated with

i. Tremor ☐ YES ☐ NO

ii. Rigidity of Movement ☐ YES ☐ NO

iii. Postural Instability ☐ YES ☐ NO

3. Is the patient treated with medication?

☐ YES ☐ NO

If Yes, please provide the details.

Name of Medication	Duration of Consumption

4. Was the disease well controlled by medication?

☐ YES ☐ NO

If Yes, please provide details.

5. Was there signs of progressive impairment?

☐ YES ☐ NO

If Yes, please provide details.

6. Is the patient able to perform the following activities without assistance?

Activities of Daily Living	YES / NO	Description for the condition
Transfer (Getting in & out of a chair without requiring physical assistance)	☐ YES ☐ NO	
Mobility (The ability to move from room to room without requiring any physical assistance)	☐ YES ☐ NO	
Continence (The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene)	☐ YES ☐ NO	
Dressing (Putting on and taking off all necessary items of clothing without requiring assistance of another person)	☐ YES ☐ NO	
Bathing/ Washing (The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means)	☐ YES ☐ NO	
Eating (All tasks of getting food into the body once it has been prepared)	☐ YES ☐ NO	

Please provide copies of all relevant reports. (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, All Neurological reports and relevant reports, All hospital reports or relevant reports, Cerebral Angiogram, etc.)

SECTION K

- **Diagnosis of Alzheimer's Disease or Dementia**
- **Alzheimer's Disease or Dementia (Moderate / Severe)**

(To be completed by the Neurologist)

1. What was the underlying cause of the dementia?

i. Alzheimer's Disease ☐ YES ☐ NO

ii. Vascular Dementia, please give details ☐ YES ☐ NO

iii. Neurosis or Psychiatric Illness, please give details ☐ YES ☐ NO

iv. Drug related Brain Disorder, please specify the drug ☐ YES ☐ NO

v. Alcohol related Brain Damage, please give details ☐ YES ☐ NO

2. Is there a permanent clinical loss of ability to do all of the following ?

i. Remember ☐ YES ☐ NO

ii. Reason ☐ YES ☐ NO

iii. Perceive, understand, express and give effect to ideas ☐ YES ☐ NO

3. Was there significant reduction in mental and social functioning?

i. Deterioration or loss of intellectual capacity ☐ YES ☐ NO

ii. Abnormal behavior ☐ YES ☐ NO

Please state the scores of the Mini Mental State Examination (MMSE) or any equivalent tests done

4. Does the patient require continuous supervision?

☐ YES ☐ NO

If Yes, please provide details.

5. Is the disease reversible?

☐ YES ☐ NO

Please provide the score for Mini-mental state examination (MMSE) and all supporting clinical questionnaires / test results including imaging reports. (E.g. Radiological, CT scanning, Imaging reports, Blood and laboratory test results, All Neurological reports and relevant reports, Cerebral Angiogram, All questionnaires and test reports, etc.)

SECTION L

- **Stroke**
- **Carotid Artery Surgery**
- **Stroke Treatment by Carotid Artery Angioplasty & Stent**
- **Surgery for Subdural Haematoma due to Accident**

(To be completed by the Neurologist)

1. Patient's physical and mental status on last consultation

i. Physical

ii. Mental

2. Is there continuous improvement in the signs/symptoms of the patient's neurological deficit ?

☐ YES ☐ NO

3. Please provide the details below.

a. Did the patient suffer from a neurological deficit?	☐ YES ☐ NO	If Yes, please state the duration of deficit. ☐ Hours ☐ Days
b. If the patient is suffering from coma, how long was the patient in coma?	☐ YES ☐ NO	If Yes, please state the duration. ☐ Months
c. Are the neurological deficit permanent and with persisting clinical symptoms/ signs?	☐ YES ☐ NO	If Yes, please describe the persisting symptoms/ signs.
d. Is the patient still on follow-up treatment ?	☐ YES ☐ NO	If Yes, please provide the last follow up date. ☐ Day ☐ Month ☐ Year

4. Please provide the most recent date that a complete neurological assessment was done.

☐ Day ☐ Month ☐ Year

5. When do you think the patient would recover from the neurological deficits (if any) as a result of the stroke.

☐ Day ☐ Month ☐ Year

6. Please confirm if the neurological deficits would most likely be persistent throughout the lifetime of the patient.

☐ YES ☐ NO

7. If unable to answer question (5) and (6) above, please suggest a date that the patient will undergo another neurological assessment.

☐ Day ☐ Month ☐ Year

8. What was the underlying cause of the condition?

☐ Infarction of brain tissue
☐ Arterio-venous Malformation
☐ Embolization from an extra-cranial source
☐ Head injury
☐ Cerebral Haemorrhage
☐ Carotid artery narrowing
☐ Others, to specify

9. Is the diagnosis falling within any of the following conditions?

i. Transient Ischaemic Attack ☐ YES ☐ NO
ii. Any reversible ischaeic neurological deficit ☐ YES ☐ NO
iii. Vertebrobasilar ischaemia ☐ YES ☐ NO
iv. Cerebral symptoms due to migraine ☐ YES ☐ NO
v. Cerebral injury resulting from trauma or hypoxia ☐ YES ☐ NO
vi. Vascular disease affecting the eye or optic nerve or vestibular functions ☐ YES ☐ NO

10. Was there narrowing of the carotid artery ?

☐ YES ☐ NO

If Yes, please provide percentage of narrowing.

☐ %

11. Did the patient suffer stroke as a result of the carotid artery narrowing?

☐ YES ☐ NO

12. Please select (√) the surgical intervention done on the Carotid Artery,

☐ Endarterectomy

☐ Carotid Angioplasty & stent placement

☐ Other, to specify ☐

Please provide the following details on the procedure done,

Date (DD/MM/YYYY)	Name of the doctor/surgeon	Hospitals

Please provide copies of all relevant reports (E.g. Radiological, CT scanning, arteriography, Imaging reports, Blood and laboratory test results, All Neurological reports and relevant reports, Carotid Artery surgery report, etc.)

SECTION M ▪ Coma *(To be completed by the Neurologist)*

1. Date and time of onset.

☐ Day ☐ Month ☐ Year ☐ am/pm

2. Was the patient put on life support system ?

☐ YES ☐ NO

If Yes , for how long.

☐ Hours

3. What is the extent of coma under the Glasgow Coma Scale or any other measurement for coma ? Please state type of measurement.

☐

4. Please provide the date and time of emergence from coma and resulting patient's limitations both physical and mental since then.

☐ Day ☐ Month ☐ Year ☐ am/pm

Limitation:

☐

5. Are there any neurological deficits lasting more than 30 days after the patient awoke from coma / regain consciousness?

☐ YES ☐ NO

If Yes, please provide details of neurological deficit and duration of the deficit.

☐

6. Is the coma resulting from any of the following?

i. Alcohol	☐ YES	☐ NO
ii. Drug abuse/ misuse	☐ YES	☐ NO
iii. Self-inflicted injury	☐ YES	☐ NO
iv. Medically induced	☐ YES	☐ NO

Please provide copies of all relevant reports. (E.g. Hospital bills on Life Support Systems billing, Glasgow Coma Scale Report certified by a Neurologist, Radiological, CT scanning, Imaging reports, Laboratory reports as well as any other tests certified by a Neurologist, etc.)

SECTION N : 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 O : 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 Doctor :