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Butterworth Tel:04-323 4200/2 Fax: 04-323 4209 **Ipoh** Tel:05-241 3895 Fax: 05-241 3904 **Johor Bahru** Tel:07-387 1066 Fax:07-387 3166

Klang Tel:03-3324 9896 Fax:03-3323 1955/3324 9946 **Kluang** Tel:07-771 1066/774 1066 Fax:07-772 1066

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Kuala Terengganu Tel:09-631 8550/9550 Fax:09-631 7550 **Kuantan** Tel:09-516 5620/1 Fax:09-516 5622 **Kuching** Tel:082-417 858 Fax:082-428 857

Melaka Tel:06-281 3382 Fax:06-281 2762 **Miri** Tel:085-321 453/4 Fax:085-321 403 **Penang** Tel:04-899 4340 Fax:04-899 0018

Sandakan Tel:089-272 168 Fax:089-272 163 **Sitiawan** Tel:05-688 1895 Fax:05-688 4897 **Taiping** Tel:05-805 3895/7 Fax:05-807 3904

Tawau Tel:089-777 811/2 Fax:089-777 813 **Teluk Intan** Tel:05-621 7325/621 7491 Fax:05-621 5692

MEDICAL ATTENDANT'S REPORT ON CRITICAL ILLNESS (Aorta Surgery/ Heart Valve Replacement)

This report is to be completed by a registered medical practitioner at the own expense of claimant.

1. a) Patient's Name b) New IC / Passport No. c) Date of Birth d) Present Occupation	_____ _____ Date : _____ _____
2. a) Please describe the exact details of the patient's condition. b) Date of last visit	_____ _____ _____ Date : _____
3. a) When did the patient first consult you for the condition? b) Symptoms presented at first consultation c) Date of symptoms first appeared prior to first consultation	Date : _____ _____ _____ Date : _____
4. a) Please give full details of the diagnosis b) Date of diagnosis c) Name and address of doctor who established the diagnosis d) Was the patient informed of the diagnosis? If yes, when and by whom?	_____ Date : _____ _____ _____ Yes ☐ Doctor's name : _____ No ☐ Date : _____
5. a) Had the patient suffered any previous episodes of the condition or any other conditions leading to it or relating to it? If yes, please give full details.	Yes ☐ No ☐ Details : _____ _____ _____ _____

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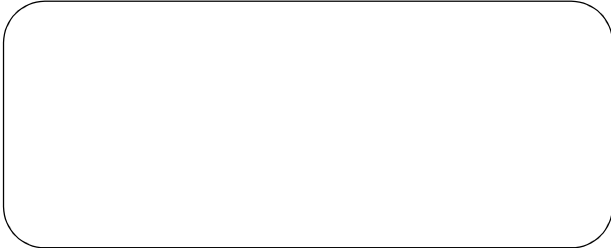
c) Cardiovascular Disease			
d) Other Illnesses/ Injuries Please specify:			
i.	i.	i.	i.
ii.	ii.	ii.	ii.
11) Please give other information which you feel would be helpful in the assessment of the patient's claim.			

Doctor's signature _____ Date : _____

Doctor's name: _____

Doctor's qualification: _____

Clinic's rubber stamp:



Telephone No.: _____