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MEDICAL ATTENDANT'S REPORT ON CRITICAL ILLNESS
(Chronic Aplastic Anaemia)

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 : __________ __________ __________ __________

6. a) Was the patient referred to you? If yes, please give name and address of doctor concerned. b) Name and address of doctor(s) who attended to the patient prior to his/her consultation with you. c) Name and address of doctor(s) who is concurrently treating the patient for the condition together with you. d) Was the patient referred to any other doctor(s) by yourself? Please give name and address of the doctor(s).	______________________ ______________________ ______________________ ______________________ ______________________ ______________________ ______________________ ______________________ ______________________ ______________________ ______________________ ______________________
7. a) Was the bone marrow failure resulted in : i. Anaemia ii. Neutropenia iii. Thrombocytopenia b) Was a bone marrow biopsy performed? If yes, please give details and enclose a copy of the biopsy report for reference.	 Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Details : ______________________ ______________________ ______________________
8. Please state the likely cause of the condition, if known to you.	______________________ ______________________
9. Please provide details of treatment.	
a) Blood product transfusion. b) Marrow stimulating agents. c) Immunosuppressive agents. d) Bone marrow transplantation.	Details : ______________________ ______________________ Details : ______________________ ______________________ Details : ______________________ ______________________ Details : ______________________ ______________________
10. Had any other investigation test or procedures been performed? If yes, please give details and enclose a copy of report.	Yes ☐ No ☐ Details : ______________________ ______________________ ______________________

11. Had the patient been treated for any of the following illnesses? If yes, please provide additional information as per the table below.			
	Date of Diagnosis/Onset (dd/mm/yyyy)	Name & address of Doctor(s) consulted	Date of Consultation (dd/mm/yyyy)
a) Hypertension			
b) Diabetes Mellitus			
c) Cardiovascular Disease			
d) Other Illnesses/ Injuries Please specify: i. ii.	i. ii.	i. ii.	i. ii.

12. 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.: ____________