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MEDICAL ATTENDANT'S REPORT ON CRITICAL ILLNESS
(Motor Neuron Disease)

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. **Please answer the questions below in respect of the patient's condition.**

a) Please describe the neurological abnormalities that your patient had experienced.

Neurological Abnormalities	Please tick (✓) the relevant column		Duration
	Yes	No	
Spiral muscular atrophy			
Progressive bulbar palsy			
Amyotrophic lateral sclerosis			
Primary lateral sclerosis			

b) What treatment is your patient currently receiving?

_____

_____

_____

c) Had the patient's condition resulting in permanent neurological deficit? If yes, please give details.

Yes ☐ No ☐

Details : _____

_____

_____

8. Had any other investigative tests or procedures been performed? If yes, please give details and enclose a copy of the report.

Yes ☐ No ☐

Details : _____

_____

_____

9. 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.
10) 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.: _____