Berjaya Sompo Insurance Berhad (62605-U)

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MEDICAL ATTENDANT'S REPORT ON CRITICAL ILLNESS
(Muscular Dystrophy)

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	Date :_____
d) Present Occupation	_____
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?	Date : _____
b) Symptoms presented at first consultation	_____ _____
c) Date of symptoms first appeared prior to first consultation	Date :_____
4. a) Please give full details of the diagnosis	_____
b) Date of diagnosis	Date : _____
c) Name and address of doctor who established the diagnosis	_____ _____ _____
d) Was the patient informed of the diagnosis? If yes, when and by whom?	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. Had any of the patient's natural parents or siblings, whether living or dead, suffered from the/or any similar conditions? If yes, please provide the following details. a) Relationship b) Diagnosis c) Age of Onset d) Date of Onset	Yes ☐ No ☐ _____ _____ _____ Date : _____
8. Was the diagnosis confirmed by electromyogram (EMG), muscle biopsy? If yes, please give details. e) Electromyogram (EMG) f) Muscle biopsy g) Blood Test h) Genetic Test	 Yes ☐ No ☐ Details : _____ Yes ☐ No ☐ Details : _____ Yes ☐ No ☐ Details : _____ Yes ☐ No ☐ Details : _____
9. a) Was there any clinical presentation of absence of sensory disturbances, normal cerebrospinal fluid and mild tendon reflex reduction? If yes, please give details on the findings b) Which were the muscles involved?	Yes ☐ No ☐ 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.: _____