هوڠ ليوڠ م. س. أ. ج. تكافل
HongLeong MSIG Takaful

CF02900001

Claim No.: _____

MEDICAL ATTENDANT'S REPORT ON HOSPITALISATION CLAIM

This report is to be completed by the registered medical practitioner at the own expense of Participant / Claimant.

1.	a) Name of Participant.	a)	
	b) I/C No.	b) Old:	New:
	c) Date of Birth.	c)	
	d) Present Occupation. (If more than one, please state all)	d)	
	e) Takaful Certificate No.	e)	
2.	Hospitalisation In Ward.		
	a) Date admitted.	a)	
	b) Time admitted.	b)	AM PM
	c) Date discharge.	c)	
	d) Time discharge.	d)	AM PM
3.	Hospitalisation In ICU.		
	a) Date admitted.	a)	
	b) Time admitted.	b)	AM PM
	c) Date discharge.	c)	
	d) Time discharge.	d)	AM PM

4. a) Diagnosis if hospitalisation is caused by illness:	a) i) ii) iii)
b) Date first diagnosed for:	b) i) ii) iii)
c) Date patient was informed of:	c) i) ii) iii)
5. a) Type and site of injuries sustained if hospitalisation is caused by accident:	a)
b) Date of accident.	b)
c) Time.	c) AM PM
d) Please describe the nature and extent of injuries. Were there any external and visible injuries seen as a result of the accident?	d)
6. Details and results of any investigations / tests done for:	
i) Diagnosis / Injury	i)
ii) Diagnosis / Injury	ii)
iii) Diagnosis / Injury	iii)
7. Cause and pathology of:	
i) Diagnosis / Injury	i)
ii) Diagnosis / Injury	ii)
iii) Diagnosis / Injury	iii)

8. Type of treatment given for: i) Diagnosis / Injury ii) Diagnosis / Injury iii) Diagnosis / Injury	 i) ii) iii)
9. Type of surgery performed for: i) Diagnosis / Injury ii) Diagnosis / Injury iii) Diagnosis / Injury	 i) ii) iii)
10. Date surgery was performed for: i) Diagnosis / Injury ii) Diagnosis / Injury iii) Diagnosis / Injury	 i) ii) iii)
11. Date when patient first consulted you for: i) Diagnosis / Injury ii) Diagnosis / Injury iii) Diagnosis / Injury	 i) ii) iii)
12. Symptoms presented: i) Diagnosis ii) Diagnosis iii) Diagnosis	 i) ii) iii)

13. Since when the symptoms had existed: i) Diagnosis ii) Diagnosis iii) Diagnosis	 i) ii) iii)
14. a) Names & addresses of referral doctors: i) Diagnosis ii) Diagnosis iii) Diagnosis b) Names & addresses of other doctors attended to patient for: i) Diagnosis ii) Diagnosis iii) Diagnosis	Date first consulted Name and Address of Doctor(s) i) ii) iii) Date first consulted Name and Address of Doctor(s) i) ii) iii)
15. Is patient referred for follow up treatment? If "Yes", kindly provide us with the following details: What is the follow up for? a) Oral medication only - if yes, please describe in details: i) Name of medication. ii) Exact duration for medication.	Yes ☐ No ☐ a) i) ii)

b) Laboratory tests - if yes, please describe in details:	b)
i) Name / Type of laboratory tests.	i)
ii) Frequency of laboratory tests.	ii)
c) Surgery - if yes, please describe in details:	c)
i) Name of surgical procedure.	i)
ii) Tentative date of surgery.	ii)
iii) Prognosis after surgery.	iii)
d) Chemotherapy - if yes, please describe in details:	d)
i) Frequency of chemotherapy.	i)
ii) Exact duration of chemotherapy.	ii)
e) Physiotherapy - if yes, please describe in details:	e)
i) Frequency of physiotherapy.	i)
ii) Exact duration of physiotherapy.	ii)
f) Others - Please specify and describe in details:	f)
i) Frequency.	i)
ii) Exact duration.	ii)

16. Was diagnosis arising from or related to:	Diagnosis i	Diagnosis ii	Diagnosis iii
a) Congenital abnormality.	a) ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) Mental disorder.	b) ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) Veneral disease.	c) ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) Self inflicted injury / attempted suicide.	d) ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) Influence of alcohol / drugs.	e) ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) HIV or AIDS related complex.	f) ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) Infertility / contraception.	g) ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h) Childbirth / pregnancy / miscarriage.	h) ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i) Weight control / obesity.	i) ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j) Routine medical check up.	j) ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

17. Had this patient been treated / hospitalised in this or any other hospitals / clinics for this or any other serious disorders / injuries? If yes, please provide details:	Dates	Disease / Disorder / Diagnosis / Injury	Details of treatment / hospitalizations and investigations done	Name and Address of Doctors and Hospitals / Clinics

18. Has the patient ever been diagnosed / suffered from any of the following:	Diagnosis	Date of Diagnosis / Onset	Name and Address of Doctor(s) Consulted	Date of Treatment Consulted
a) Hypertension.	a)			
b) Diabetes Mellitus.	b)			
c) Cardiovascular Diseases.	c)			

d) Other illness(es) / injuries. If so, please provide diagnosis, date of diagnosis / onset, names and addresses of all doctors consulted and dates of consultation.	d)
19. Please give any other information which you feel would be helpful in the assessment of your patient's claim.	

We would be most grateful if you could send copies of any specialist or hospital reports, together with any tests, readings, or similar evidence to support the validity of your patient's claim.

Office Stamp:

Signature: _____

Name (in block capitals please): _____

Qualification: _____

Date: _____

For Office Use Only

Checked and Verified By: _____ Date: _____ Branch: _____
(Name of Staff)