MikroSayang | Great Eastern TAKAFUL

CI-03 DOCTOR'S STATEMENT - CRITICAL ILLNESS - BRAIN, NERVE AND MUSCLE

CI-03

MEDICAL REPORT TO BE COMPLETED BY THE ATTENDING PHYSICIAN/ SPECIALIST
Please attach copies of ALL relevant hospital / operation reports, laboratory and test results.
For any medical report fee incurred in completing this form, it will be borne by Person Covered.

Name of Patient (Person Covered)

New NRIC No. ☐☐☐☐☐☐ - ☐☐ - ☐☐☐☐

1	Diagnosis	
	(i) Please describe the full and exact diagnosis.	(i) _____
	(ii) Date when the illness was FIRST diagnosed?	(ii) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
	(iii) Was MRI/ CT/ EMG/ biopsy performed?	(iii) ☐ Yes ☐ No
	(iv) What is MRI/ CT/ EMG/ biopsy finding(s)? Please provide details of diagnosis	(iv) _____
	(v) Date when the MRI/ CT/ EMG/ biopsy was done	(v) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
2	(i) Is the Critical Illness associated with any other disorder, for example neurosis, psychiatric illness, HIV infection, etc.?	(i) ☐ Yes ☐ No If "YES", please give details. _____
	(ii) The conditions was associated with: (Please tick whichever is relevant)	(ii) ☐ Self-inflicted injury ☐ Drug or alcohol misuse ☐ Others: _____

3 Please tick and complete for the relevant sections:

(✓) Please tick	Items	Descriptions
☐ Stroke *(A minimum Assessment Period of 3 months applies)*	Cause of stroke:	☐ Infarct ☐ Hemorrhage ☐ Embolus ☐ TIA(Transient Ischemic Attack)
☐ Parkinson's Disease	(i) Cause of Parkinson's Disease: (ii) Can the condition / illness be controlled with medication?	(i) ☐ Idiopathic ☐ Secondary due to: _____ (ii) ☐ Yes ☐ No
☐ Motor Neurone Disease	Type of Motor Neurone Disease:	☐ Amyotrophic lateral sclerosis ☐ Progressive bulbar palsy ☐ Primary lateral sclerosis ☐ Spinal muscular atrophy
☐ Muscular Dystrophy	Type of Muscular Dystrophy:	☐ Duchenne's ☐ Myotonic ☐ Facioscapulohumeral ☐ Congenital ☐ Others: _____
☐ Alzheimer's Disease	Type of conditions involved:	☐ Alzheimer's disease ☐ Severe Dementia ☐ Other degenerative brain disorders _____
☐ Major Head Trauma *(A minimum Assessment Period of 3 months applies)*	Where is the exact location and extent of the head injury?	_____ _____ _____ _____
☐ Coma *(A minimum Assessment Period of 30 days applies)*	(i) How long was the Person Covered in a state of coma, with no response to external stimuli? (ii) Was the coma 'Medically induced'? (iii) How long was the Person Covered on a ventilator?	(i) _____ hours / _____ days since ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) _____ am/pm (ii) ☐ Yes ☐ No (iii) _____ hours / _____ days First on ventilation since : ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

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(✓) Please tick	Items	Descriptions
☐ Benign Brain Tumour	(i) Is the tumour life threatening?	(i) ☐ Yes ☐ No If "YES", please give details. _____
	(ii) Are there signs of increased intracranial pressure?	(ii) ☐ Yes ☐ No If "YES", please give details. _____
	(iii) Has it caused damage to the brain?	(iii) ☐ Yes ☐ No If "YES", please give details. _____
☐ Bacterial Meningitis / Encephalitis *(A minimum Assessment Period of 30 days applies)*	Please provide Cerebrospinal Fluid (CSF) test results	_____ _____ _____ _____ _____
☐ Brain Surgery	(i) Please state type of surgery:	(i) ☐ Craniotomy ☐ Craniectomy ☐ Other procedure : _____
	(ii) Reason for surgery:	(ii) _____
	(iii) Was the surgery done due to injuries sustained during an accident?	(iii) ☐ Yes ☐ No
	(iv) Please state date of surgery:	(iv) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
☐ Paralysis/Paraplegia/ Loss of Independent Existence *(A minimum Assessment Period of 6 months applies)*	(i) Caused by	(i) ☐ Accident ☐ Illness
	(ii) Date of trauma or illness	(ii) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
	(iii) Please provide details of the accident / medical conditions	(iii) _____
☐ Multiple Sclerosis *(A minimum Assessment Period of 6 months applies)*	(i) Was there involvement of the optic nerves, brain stem and spinal cord?	(i) ☐ Yes ☐ No
	(ii) Type of investigations/ tests done to confirm the diagnosis	(ii) ☐ MRI brain scan ☐ Analysis of cerebrospinal fluid ☐ Clinical ☐ A test of nerve responses
☐ Apallic syndrome (ie. Persistent Vegetative State (PVS))	(i) Please specify the cause of the Apallic Syndrome:	(i) _____
	(ii) If due to accident, please state: (a) Date of Accident:	(ii)(a) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
	(b) Description of how the accident happened:	(ii)(b) _____
	(iii) Is there presence of universal necrosis of the brain cortex with the brainstem intact?	(iii) ☐ Yes ☐ No
	(iv) Was patient under Vegetative state? If Yes, please state the date:	(iv) ☐ Yes ☐ No Since ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) Until ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
☐ Poliomyelitis	(i) What is/are the underlying cause(s) of the illness? Please state the specific causative agent.	(i) _____
	(ii) Was there paralysis of the patient's limb muscles ? If "Yes", please provide full details of the impaired motor function in Question 4.	(ii) ☐ Yes ☐ No
	(iii) Was there paralysis of the patient's respiratory muscles? If "Yes", please provide full details of the impaired of respiratory function in Question 4.	(iii) ☐ Yes ☐ No
	(iv) How long has the patient been suffering from the impaired motor function and/or respiratory function due to Poliomyelitis?	(iv) _____ months

☐ Elephantiasis	(i) Which of the following type of Elephantiasis does the patient have?	(i) ☐ Lymphatic Filariasis ☐ Lymphoedema ☐ Acute Lymphangitis ☐ Others: (please specify) _____
	(ii) Which part(s) of patient's body has severe swelling?	(ii) _____
	(iii) Was there any damage to patient's lymphatic system?	(iii) ☐ Yes ☐ No
	(iv) Was there permanent lymphatic obstruction?	(iv) ☐ Yes ☐ No
	(v) Is the lymphoedema caused by infection with a sexually transmitted disease, trauma, postoperative scarring, congestive heart failure, or congenital lymphatic system abnormalities?	(v) ☐ Yes ☐ No
	(vi) Please provide laboratory tests result showing presence of filariae antigen or microfilariae.	(vi) _____
☐ Creutzfeldt-Jakob Disease (Mad Cow Disease)	(i) Type of CJD disease :	(i) ☐ Sporadic (or classical) CJD ☐ Inherited (or familial) CJD ☐ Variant CJD (vCJD) ☐ Iatrogenic CJD For iatrogenic JCD, please specify the medical procedure done or the source of transmission: ☐ Blood transfusion ☐ Use of human growth hormones ☐ Organ transplant / graft ☐ Others: (please specify) _____
	(ii) Is this illness solely responsible for the Person Covered's current symptoms?	(ii) ☐ Yes ☐ No
	(iii) Please give full details of diagnostic tests findings and results: (e.g. Electroencephalography (EEG) / Cerebrospinal Fluid (CSF) / MRI / CT scan) **Please attach the test report if any.*	(iii) _____ _____ _____

4 **Neurological Examination report:**

Please state below **(Question a - h)**, the Person Covered's physical and neurological impairments, **based on latest / current assessment:**

Date when neurological impairments were first noted: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

Date of latest/current assessment: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

(a) Vision (Visual Acuity)

	Right	Left
Normal		
Impaired		
Scores based on Metric Acuity		

Remarks: _____

(b) Hearing (Supported by an Audiometry results)

	Right	Left
Normal		
Impaired		
Scores based on speech reception threshold	dB	dB

Remarks: _____

(c) Function of speech

☐ Clear and understandable
☐ Slurred
☐ Unable to speak

Remarks: _____

(d) Cognitive function

☐ Normal
☐ Poor comprehension
☐ Difficult with logic and reasoning
☐ Memory loss

Remarks: _____

(e) General examination findings:

(i) Are there any abnormal movements or abnormal gait?	(i) ☐ Yes ☐ No If "YES", please give details.
(ii) Is there any muscle wasting or any signs of progressive muscle weakness or impairment?	(ii) ☐ Yes ☐ No If "YES", please give details.
(iii) If there any sensory disturbances or any other significant examination findings?	(iii) ☐ Yes ☐ No If "YES", please give details.

(f) Examination of the Limbs

Please indicate the **muscle power** of the various joint in the table below with the maximum grade of 5.

Upper Limbs	**Right**	**Left**
Shoulder		
Elbow		
Wrist		
Grip		
Lower Limbs	**Right**	**Left**
Hip		
Knee		
Ankle		

(g) Assessment of Activities of Daily Living without assistance

Activities of Daily Living	**Not Limited**	**Limited**	**Incapable**
Transfer (Getting in & out of a chair without physical assistance)			
Mobility (Ability to move from room to room without physical assistance)			
Continence (Ability to voluntarily control bowel & bladder functions so as to maintain personal hygiene)			
Dressing (Putting on & taking off all necessary items of clothing without assistance of another person)			
Bathing / Washing (Ability to wash in the bath or shower, including getting in & out of bath or shower or wash by any other means without assistance of another person)			
Eating (All task of getting food into the body without assistance of another person)			

(h) Any other significant neurological examination findings or disability details that are not stated above:

_____

_____

_____

5	What is the prognosis of the Person Covered's neurological and/or motor impairment? You may tick (✓) more than one.	☐ Recovered ☐ Stable and improving ☐ Progressively worsening ☐ No change. Likely to be permanent ☐ For Multiple sclerosis - History of multiple exacerbations and remissions. Please indicate number of exacerbations since diagnosis: _____ ☐ For Alzheimer's disease - Any significant reduction in mental and social functioning requiring continuous supervision of the Person Covered? If Yes, please elaborate : _____

6	Has the patient previously had the same or similar condition?	☐ Yes ☐ No If "Yes", please state the first treatment date ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) Please state symptoms or condition presented: _____

DECLARATION: TO BE COMPLETED BY THE ATTENDING PHYSICIAN/ SPECIALIST

I, the undersigned, certify that I have examined the above Person Covered and all statement made and answers given are true and to the best of my knowledge and belief.

Signature and Official Stamp

Name: _____

Address:

Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

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