

|   | CI-0  | 5 D    | осто       | OR'S     | ST/      | ATEN         | IEN   | <b>T</b> -                                    | CR           | ITI        | CA         | LII        | L   | NES     | S -   | LIV    | 'ER      | R   | EL   | AT     | EC | ) C         | :0  | NC | ) | ΓΙΟ | NS | 5  |     |  |   |  |   |
|---|---|--------|------------|----------|----------|--------------|-------|---|--------------|------------|------------|------------|-----|---------|-------|--------|----------|-----|------|--------|----|-------------|-----|----|---|-----|----|----|-----|--|---|--|---|
|   | MEDICAL REPORT TO BE COMPLETED BY THE ATTENDING PHYSICIAN/ SPECIALIST |        |            |          |          |              |       |   |              |            |            |            | ]   | -0      | )5    | )      |          |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
| Please attach copies of ALL relevant hospital / operation reports, laboratory and test results.<br>For any medical report fee incurred in completing this form, it will be borne by Person Covered. |   |        |            |          |          |              |       |   |              |            |            |            |     |         |       |        |          |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
| Name of Patient (Person Covered)  |   |        |            |          |          |              |       |   |              |            |            |            |     |         |       |        |          | Nev | w N  | RIC    | Nc | ).          |     |    |   |     |    |    |     |  |   |  |   |
| Γ   |   |        |            |          |          |              |       |   |              |            |            |            |     |         |       |        |          |     |      |        |    |             |     |    | - |     |    | ٦. | - [ |  |   |  |   |
|   |   |        |            |          |          |              |       |   |              |            |            |            |     |         |       |        |          |     | 1    |        |    |             |     |    |   |     |    |    | L   |  |   |  |   |
| Diagnosis   |   |        |            |          |          |              |       |   |              |            |            |            |     |         |       |        |          |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
| (i) Please describe the full and exact diagnosis.   |   |        |            |          |          |              |       | (i)   |              |            |            |            |     |         |       |        |          |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
|   |   |        |            |          |          |              |       |   |              |            |            |            |     |         |       |        |          |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
|   | (ii) Date when the illness was FIRST diagnosed?                       |        |            |          |          |              |       |   |              | (ii)       |            |            |     |         |       |        |          |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
| (iii) Date test performed   |   |        |            |          |          |              |       |   | ו<br>(iii)[  |            |            |            | T   | ,<br>,  |       |        |          |     |      | dd/n   |    |             |     |    |   |     |    |    |     |  |   |  |   |
|   |   |        |            |          |          |              |       |   | l            |            |            |            |     | /       |       |        |          |     |      | a a, i |    | , , , , , , | ,,, |    |   |     |    |    |     |  |   |  |   |
| Type of test performed  |   |        |            |          |          |              |       |   | -            |            |            |            |     |         |       |        |          |     |      |        |    |             |     |    |   |     |    |    |     |  | - |  |   |
| (iv) Has the patient previously had the same or   |   |        |            |          |          |              |       |   | (iv)[        | <u>ן</u> א | 'es        |            |     | Ľ       | N     | 0      |          |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
| similar condition?  |   |        |            |          |          |              |       |   |              | lf "Y      | ′es"       | , pleas    | e s | tate tl | he fi | rst ti | reat     | mer | nt d | ate    |    |             |     |    |   |     |    |    |     |  |   |  |   |
|   |   |        |            |          |          |              |       |   | (dd/mm/yyyy) |            |            |            |     |         |       |        |          |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
|   |   |        |            |          |          |              |       | Please state symptoms or condition presented: |              |            |            |            |     |         |       |        |          |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
|   |   |        |            |          |          |              |       |   | -            |            |            |            |     |         |       |        |          |     |      |        |    |             |     |    |   |     |    |    |     |  | - |  |   |
|   |   | -      | e Liver    |          |          |              |       |   |              |            |            |            |     |         |       |        |          |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
| 1   |   |        | escribe t  |          |          |              |       | 6   |              |            |            |            |     |         |       | _      |          |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
|   | (i) Is  | there  | e any ev   | idence   | of ja    | undice       | ?     |   |              |            | (i) Yes No |            |     |         |       |        |          |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
|   | (ii) Is the jaundice likely to be permanent?                          |        |            |          |          |              |       |   | (ii) Yes No  |            |            |            |     |         |       |        |          |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
|   | (iii) Is there evidence of hepatic encephalopathy?                    |        |            |          |          |              |       |   | (iii) Yes No |            |            |            |     |         |       |        |          |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
| (iv) Is there evidence of ascites?  |   |        |            |          |          |              | (iv)[ | ו 🗌   | /es          |            |            | Γ          | N   | 0       |       |        |          |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
| 2 Is the liver disease associated with drug or alcohol  |   |        |            |          |          | 2 🗌 Yes 🗌 No |       |   |              |            |            |            |     |         |       |        |          |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
| misuse?   |   |        |            |          |          |              |       | If "YES", please give details.                |              |            |            |            |     |         |       |        |          |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
|   |   |        |            |          |          |              |       |   |              |            |            |            |     |         |       |        |          |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  | _ |
| 3   | Has   | the li | ver failu  | ire read | hed t    | he end       | stag  | le?   |              |            | 3          | <u> </u>   | Yes |         |       |        | _ N      | lo  |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
|   | Fulm  | inan   | t Viral H  | lepatit  | is       |              |       |   |              |            |            |            |     |         |       |        |          |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
| 1   | Plea  | se st  | ate the    | severity | y of ill | lness?       |       |   |              |            |            |            |     |         |       |        |          |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
|   | (i) Is  | the s  | size of li | ver rap  | idly d   | lecreas      | ing?  |   |              |            | (i) [      | <u>ן</u> ו | es  |         |       | Ľ      | _ N      | 0   |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
| (ii) Is there necrosis of entire liver lobules?   |   |        |            |          |          |              |       | (ii) [  | ו 🗌          | /es        |            |            |     | ] N     | 0     |        |          |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
| (iii) Is there deterioration of liver function tests?   |   |        |            |          |          |              |       | (iii)[  | <u>ו</u> ר   | /es        |            |            |     | ] N     | 0     |        |          |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
|   | (iv) I  | s the  | jaundic    | e deep   | eninc    |              | oning | 12  |              |            | (iv)[      | 一、         | /~~ |         |       | г      | <b>-</b> |     |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |
|   | (14) 1  |        |            |          | Crimig   | j/wors       | ennig | J ·   |              |            | ()         | י          | es  |         |       | L      | N        | 0   |      |        |    |             |     |    |   |     |    |    |     |  |   |  |   |

CLM-MSDSCI05-V00-032021-TAKAFUL

| C   | Chronic Relapsing Pancreatitis  |   |  |  |  |  |  |  |  |  |  |  |
|---|---|---|--|--|--|--|--|--|--|--|--|--|
| 1   | Diagnosis:<br>(i) The patient was diagnosed of  | (i) Acute pancreatitis Chronic pancreatitis |  |  |  |  |  |  |  |  |  |  |
|   | (ii) What caused the pancreatitis episodes?   | (ii)  |  |  |  |  |  |  |  |  |  |  |
|   | (iii) Is the pancreatitis caused by drug or alcohol use?  | (iii) Yes No                                |  |  |  |  |  |  |  |  |  |  |
| 2   | Details of diagnosis :<br>(i) Has the patient's pancreatitis lasted more than<br>THREE (3) attacks?   | (i) 🗌 Yes 🗌 No                              |  |  |  |  |  |  |  |  |  |  |
|   | <ul><li>(ii) If "Yes", please state:</li><li>(a) Date of 1st (FIRST) attack:</li></ul>  | (ii)(a) / / (dd/mm/yyyy)                    |  |  |  |  |  |  |  |  |  |  |
|   | (b) Date of 2nd (SECOND) attack:  | (ii)(b) / / (dd/mm/yyyy)                    |  |  |  |  |  |  |  |  |  |  |
|   | (c) Date of 3rd (THIRD) attack:   | (ii)(c) / (dd/mm/yyyy)                      |  |  |  |  |  |  |  |  |  |  |
|   | (d) Date of 4th (FOURTH) attack:  | (ii)(d) / / (dd/mm/yyyy)                    |  |  |  |  |  |  |  |  |  |  |
|   | (iii) Is there any permanent pancreatic dysfunction<br>causing malabsorption?   | (iii) Yes No                                |  |  |  |  |  |  |  |  |  |  |
|   | (iv) Will patient needs enzyme replacement therapy?   | (iv) Yes No                                 |  |  |  |  |  |  |  |  |  |  |
| 3   | Investigation:  |   |  |  |  |  |  |  |  |  |  |  |
|   | <ul> <li>(i) Was there Endoscopic Retrograde<br/>Cholangio-Pancreatography (ERCP) done to<br/>confirm the diagnosis?</li> </ul>   | (i) Yes No                                  |  |  |  |  |  |  |  |  |  |  |
|   | (ii) If "Yes", please provide below:  |   |  |  |  |  |  |  |  |  |  |  |
|   | (a) The date of ERCP performed:   | (ii)(a) / / (dd/mm/yyyy)                    |  |  |  |  |  |  |  |  |  |  |
|   | (b) Please provide the findings/results:  | (ii)(b)                                     |  |  |  |  |  |  |  |  |  |  |
|   |   |   |  |  |  |  |  |  |  |  |  |  |
|   | (iii) If "No", please provide the reason(s):  | (iii)                                       |  |  |  |  |  |  |  |  |  |  |
|   |   |   |  |  |  |  |  |  |  |  |  |  |
| DECLARATION: TO BE COMPLETED BY THE ATTENDING PHYSICIAN/ SPECIALIST |   |   |  |  |  |  |  |  |  |  |  |  |
| l,<br>b   | 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. |   |  |  |  |  |  |  |  |  |  |  |
| [   |   | Name:                                       |  |  |  |  |  |  |  |  |  |  |

|                              | Name:    |  |
|------------------------------|----------|--|
|                              | Address: |  |
|                              |          |  |
|                              |          |  |
| Signature and Official Stamp | Date:    |  |
|                              |          |  |