MikroSayang Great Eastern TAKAFUL

CI-07 DOCTOR'S STATEMENT - CRITICAL ILLNESS - HIV RELATED CONDITIONS

CI-07

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. ____ - ____ - ____

Diagnosis

(i) Please describe the full and exact diagnosis. — (i) _____

(ii) Date when the illness was FIRST diagnosed? — (ii) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

(iii) Is there a HIV antibody test or Western Blot test performed? — (iii) ☐ Yes ☐ No

(iv) What is the HIV Test result?
HIV antibody test 1 — (iv) ☐ Positive ☐ Negative ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
HIV antibody test 2 — ☐ Positive ☐ Negative ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
Western Blot Test — Result:_____ Report Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

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

HIV Infection Due to Blood Transfusion

1. Did the Person Covered give history of any of the following:

(i) Homosexual behaviour — (i) ☐ Yes ☐ No
(ii) Multiple sexual partners — (ii) ☐ Yes ☐ No
(iii) Intravenous drug user — (iii) ☐ Yes ☐ No
(iv Haemophilia — (iv) ☐ Yes ☐ No
(v) Spouse with HIV infection — (v) ☐ Yes ☐ No

2. (i) If the HIV infection was contracted through blood transfusion, what was the reason for the blood transfusion? — (i) _____

(ii) Was the blood transfusion medically necessary or given as part of medical treatment? — (ii) ☐ Yes ☐ No

(iii) Was the blood transfusion received in Malaysia or Singapore? — (iii) ☐ Yes ☐ No Country Name: _____

(iv) Please state the date of blood transfusion. — (iv) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

(v) Is the source of HIV infection established to be from the hospital that provided the blood transfusion? — (v) ☐ Yes ☐ No
If "YES", please give the name and address of the hospital where the transfusion took place.
_____

(vi) Is the institution able to trace the origin of the HIV tainted blood? — (vi) ☐ Yes ☐ No
If "YES", please give details.
_____

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Occupationally Acquired Human Immunodeficiency Virus (HIV) Infection	
1. Is the Person Covered a registered medical staff working in Malaysia?	1. ☐ Yes ☐ No
(a) If "Yes", please check the appropriate item.	(a) ☐ General Physician ☐ Specialist ☐ Nurse ☐ Laboratory Technician ☐ Dentist ☐ Paramedics ☐ Ambulance Worker ☐ Others (please specify): _____
(b) Please provide the registration number with the Ministry of Health of Malaysia:	(b) _____
2. Was the HIV infection acquired as a result of an accident occurring during the course of carrying out normal occupational duties?	2. ☐ Yes ☐ No
(a) If Yes, please state provide details: (i) Date of Accident:	(i) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
(ii) Place of Accident:	(ii) _____
(iii) How did the Accident happened?	(iii) _____
(b) Was the HIV infection as a result of sexual activity or recreational intravenous drug use?	(b) ☐ Yes ☐ No
3. Was there a HIV test carried out within 7 days after the accident?	3. ☐ Yes ☐ No
(a) If Yes, please state provide details: (i) Date of HIV test taken:	(i) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
(ii) Results:	(ii) ☐ Positive ☐ Negative
4. Was there a HIV test carried out to confirm the diagnosis after the accident?	4. ☐ Yes ☐ No
(a) If Yes, please state provide details: (i) Date of HIV test taken:	(i) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
(ii) Results:	(ii) ☐ Positive ☐ Negative

Full-Blown AIDS

1 (i) What was the latest CD4 cell count?	(i) Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) CD4 cell count: _____
(ii) Did the Person Covered lose any weight over the past 6 months?	(ii) ☐ Yes ☐ No
(iii) If "YES", what is the percentage (%) of weight loss?	(iii) _____ % of weight loss
(iv) Is there Kaposi sarcoma?	(iv) ☐ Yes ☐ No
(v) Is there Pneumocystitis Carinii Pneumonia?	(v) ☐ Yes ☐ No
(vi) Is there Progressive multifocal leukoencephalopathy?	(vi) ☐ Yes ☐ No
(vii) Is there active tuberculosis?	(vii) ☐ Yes ☐ No
(viii) Is there malignant lymphoma?	(viii) ☐ Yes ☐ No
(ix) What was the latest lymphocyte count?	(ix) Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) Lymphocyte count : _____

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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