



CI-08 DOCTOR'S STATEMENT - CRITICAL ILLNESS - OTHERS CRITICAL ILLNESS									
F	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.								
1	Name of Patient (Person Covered)		New NRIC No.						
		$oxed{\mathbb{L}}$							
	Diagnosis								
	(i) Please describe the full and exact diagnosis.	(i)							
		(ii)							
(ii) Date when the illness was FIRST diagnosed?			(dd/mm/yyyy)						
	(iii) Has the patient previously had the same or	│ (iii)							
	similar condition?	` ′	If "Yes", please state the first treatment date						
			/ (dd/mm/yyyy)						
			Please state symptoms or condition presented:						
	Chronic Aplastic Anemia – resulting in permanent Bor	ne M	Marrow Failure						
1	Is bone marrow failure irreversible and permanent?	1	☐ Yes ☐ No						
2	What treatment(s) is currently being administered?	2	Regular blood product transfusion;						
_	That it cannot in (c) to carrottely borning assumments of	_	Marrow stimulating agents;						
			Immunosuppressive agents; or						
			Bone marrow transplantation						
3	Was Bone Marrow biopsy and other tests done to	3	☐ Yes ☐ No						
verify the diagnosis? Please provide bone marrow biopsy results & results of									
	other tests. Major Organ/ Bone Marrow Transplant								
1	Please provide the details of transplant surgery	1							
•	performed.								
2	Does the surgery involve the receipt from the transplant of:	2	Human bone marrow using hematopoietic stem cells preceded by total bone marrow ablation						
			$\hfill \Box$ One of the following organ that resulted from irreversible end stage failure :-						
			☐ Heart ☐ Liver ☐ Kidney						
			☐ Lung ☐ Pancreas ☐ Others, please specify:						
3	Date of Transplant?	3	/((dd/mm/yyyy))						
	Third Degree Burns - of specified severity								
1	(i) What was the cause of the burns?	(i)							
			If accidents, please give details of:						
			Date: (dd/mm/yyyy)						
			Where did it occur :						
			How did it occur :						
	(ii) Was the burns self-inflicted?	(ii)	☐ Yes ☐ No						
		(")	Please give full details						

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	Third Degree Burns - of spe	ecified severity						
2	What is the percentage (%) of Total Body Surface Area (TBSA) burns as measured by "The Rule of 9" of the	2	Depth of Burn	Area affected and Percentage	ge (%) Affected			
	Lund & Browder ?			1st Degree				
				2nd Degree				
				3rd Degree				
				4th Degree				
	Progressive Scleroderma							
1	(i) Which form of scleroderm	a does the patient have?	(i)					
				Localised sclerod				
	(ii) Please state if patient is s	suffering from the following:	(ii)	(ii) Localised scleroderma (linear scleroderma or morphea) CREST syndrome				
				Eosinophilic fasci				
				None of the abov	е			
2	Please describe the extent of	f the illness:						
	(i) Was the skin involved? Please specify the body at	rea affected?	(i)	Yes	□ No			
	(ii) Was the blood vessels inv	volved?	(ii)	Yes	☐ No			
	(iii) Was the heart involved?		(iii)	Yes	No			
	(iv) Were the lungs involved?	?	(iv)	Yes	☐ No			
	(v) Were the kidneys involved	d?	(v)	Yes	☐ No			
3	Please provide details of invectorism the diagnosis.	estigations performed to						
	(i) Serology:(a) The date of test perform	med:	(i)(a	(i)(a) / (dd/mm/yyyy)				
	(b) Please provide the find	lings/results:	(i)(k	o)				
	(ii) Biopsy:							
	(a) The date of test perform		(ii)((ii)(a) / (dd/mm/yyyy)				
	(b) Please provide the findings/results:			(ii)(b)				
	End-Stage Lung Disease							
1	(i) Does the Person Covered	d have dyspnea at rest?	(i)	Yes	☐ No			
	(ii) Is Person Covered on co therapy at present?	(ii) Is Person Covered on continuous permanent oxygen (ii) Yes No therapy at present?						
	(ii) How is the oxygen administered at home? (iii)							
2	Please provide details of the lung function tests done (including			ng dates and results)				
	Lung Function Tests	Date:	Dat	e:	Date:	Date:		
	FEV1							
					·			

End-Stage Lung Disease									
3	Please provide details of all arterial blood gas (ABG) analysis done (including dates and results)								
	Arterial Blood Gas Analysis	Date:	Date:	Date:	Date:				
	PaO2								
ı	DECLARATION: TO BE COMPLETED BY THE ATTENDING PHYSICIAN/ SPECIALIST								
ŀ	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:								
	Address:								
Signature and Official Stamp Date: / / / / (dd/mm/yy					·/yyyy)				
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