Great Eastern TAKAFUL X PERLINDUNGAN tenang MAMPU & MUDAH

CI-08 DOCTOR'S STATEMENT - CRITICAL ILLNESS - OTHERS CRITICAL ILLNESS

MEDICAL REPORT TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SPECIALIST

CI-08

Certificate No.

New NRIC No. - -

Certificate No.

Name of Patient (Person Covered)

The above name is covered with GREAT EASTERN TAKAFUL BERHAD against the happening of certain contingent events associated with his / her health. A claim has been submitted within the coverage of a Critical Illness benefit and to enable us to assess the claim, kindly complete this confidential report.
(For any medical report fee incurred in completing this form, it will be borne by claimant)

1 Declaration to be completed by Attending Physician/ Specialist

I hereby certify that :

☐ I am the patient's attending doctor, and I have personally examined and treated the patient for the illnesses and injuries sustained; OR

☐ This medical report has been prepared on behalf of the treating doctor based on medical records.

Name:

Signature and Official Stamp

2 Medical History

(i) Has the Person Covered previously suffered from or detected to have hypertension, diabetes, angina, hyperlipidaemia, cardiovascular disease, transient ischaemic attack, neurological disorders, renal disease, hepatitis B or C, autoimmune disorder or any other significant illnesses? ☐ Yes ☐ No If "Yes", please provide the following:

Medical Condition	Date of Diagnosis	Medication/Treatment	Name of Treating Doctor	Name & Address of Clinic / Hospital

3 Diagnosis

(i) Please describe the full and exact diagnosis	
(ii) Date when the illness was FIRST diagnosed	/ / (DD/MM/YYYY)
(iii) Date when Person Covered FIRST became aware of the illness	/ / (DD/MM/YYYY)

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(iv) What is the underlying cause of the illness as per diagnosis above?	
(v) Date when the underlying cause in (iv) was FIRST diagnosed?	☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

(vi) Please state the symptoms presented during the date of FIRST consultation
(Please indicate what had prompted the Person Covered to see you).

Symptoms	Date symptoms first started (dd/mm/yyyy)	Based on your professional opinion, what is the duration of symptoms presented prior to first consultation?

What is the source of this information?

☐ Patient

☐ Referring doctor / hospital. Please state:

Hospital	Address	Name of Consultant	Date of Consultation

☐ Others, please specify:

_____

Ebola Haemorrhagic Fever

(i) Was the presence of the Ebola virus confirmed by laboratory testing?	☐ Yes ☐ No
(ii) Date of confirmation Please provide us with a copy if the laboratory test results confirming the presence of the Ebola virus.	☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)
(iii) Did the patient experience bleeding? (Tick all that apply)	☐ Mucosal bleeding ☐ Gastrointestinal bleeding ☐ Others, please specify: _____

Severe Haemophilia

(i) Please tick the type of Haemophilia	☐ Hemophilia A (VIII Deficiency) ☐ Hemophilia B (IX Deficiency) ☐ Hemophilia C (XI Deficiency) ☐ Acquired Hemophilia ☐ Others, please specify: _____
(ii) Factor activity level (percentage of normal clotting factor):	☐ <1% of normal (severe) ☐ 1-5% of normal (moderate) ☐ 6-40% of normal (mild) ☐ 50-150% normal
(iii) Date of confirmation Please provide us with a copy if the laboratory test results confirming the presence of the Ebola virus.	☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)

Chronic Aplastic Anemia – resulting in permanent Bone Marrow Failure	
(i) Is bone marrow failure irreversible and permanent?	☐ Yes ☐ No
(ii) Please tick the condition presence for current diagnosis	☐ Anaemia ☐ Neutropenia ☐ Thrombocytopenia
(iii) What treatment(s) is currently being administered? (Please select all treatments administered)	☐ Regular blood product transfusion; ☐ Marrow stimulating agents; ☐ Immunosuppressive agents; or ☐ Bone marrow transplantation
(iv) Was Bone Marrow biopsy and other tests done to verify the diagnosis?	☐ Yes ☐ No If "No", please provide the reason of biopsy not performed _____
(v) Please provide bone marrow biopsy results & results of other tests	
Major Organ/ Bone Marrow Transplant	
(i) Please provide full and exact details of the diagnosis and disease leading to transplant surgery	
(ii) Was transplant surgery performed to patient as recipient or donor?	☐ Recipient ☐ Donor
(iii) Was the surgery performed following the transplant of	☐ Human bone marrow using hematopoietic stem cells preceded by total bone marrow ablation ☐ Heart ☐ Lung ☐ Liver ☐ Pancreas ☐ Kidney ☐ Others (please specify): _____
(iv) Does the organ transplant (heart, lung, liver, pancreas and kidney) resulted from irreversible end stage failure :-	☐ Yes ☐ No
(v) Date of Transplant?	☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY)
Third Degree Burns - of specified severity	
(i) What was the cause of the burns?	
(ii) If accidents, please give details of: Date of accident : Where did it occur : How did it occur :	☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) _____ _____

(iii) Was the burns self-inflicted?	☐ Yes ☐ No If "Yes", please specific: _____
(iv) What is the percentage (%) of Total Body Surface Area (TBSA) burns as measured by "The Rule of 9" of the Lund & Browder ?	

Depth of Burn	% TBSA Affected	Area Affected
4th Degree		
3rd Degree		
2nd Degree		
1st Degree		

Progressive Scleroderma

(i) Which form of scleroderma does the patient have?	☐ Systemic scleroderma ☐ Localised scleroderma
(ii) Please state if patient is suffering from the following:	☐ Localised scleroderma (linear scleroderma or morphea) ☐ CREST syndrome ☐ Eosinophilic fasciitis ☐ None of the above
(iii) Was the skin involved?	☐ Yes ☐ No Please specify the body area affected? _____
(iv) Was the blood vessels involved?	☐ Yes ☐ No
(v) Was the heart involved?	☐ Yes ☐ No
(vi) Were the lungs involved?	☐ Yes ☐ No
(vii) Were the kidneys involved?	☐ Yes ☐ No
(viii) Was the liver involved?	☐ Yes ☐ No
(ix) Was the pancreas involved?	☐ Yes ☐ No
(x) Were the intestinal involved?	☐ Yes ☐ No
(xi) Was the gallbladder involved?	☐ Yes ☐ No
Please provide details of investigations performed to confirm the diagnosis. (i) Serology: (a) The date of test performed: (b) Please provide the findings/ results:	☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) _____
(ii) Biopsy: (a) The date of test performed: (b) Please provide the findings/ results:	☐☐ / ☐☐ / ☐☐☐☐ (DD/MM/YYYY) _____

End-Stage Lung Disease		
(i) Does the patient have dyspnea at rest?	☐ Yes	☐ No
(ii) Is patient on continuous permanent oxygen therapy at present?	☐ Yes	☐ No
(iii) How is the oxygen administered at home?		

Please provide details of the lung function tests done (including dates and results for more than one reading)

Lung Function Tests	Date:	Date:	Date:	Date:
FEV1				

Please provide details of all arterial blood gas (ABG) analysis done (including dates and results for more than one reading)

Arterial Blood Gas Analysis	Date:	Date:	Date:	Date:
PaO2				

Note:
Please enclose copies of all reports that are available with you (including Radiological, CT scanning, Imaging reports, Blood and laboratory test results, Surgical Report for Major Organ Transplantation and any relevant reports that are available). If not submitted, company reserves the right to defer for further verification.

Declaration to be completed by Attending Physician/ Specialist

I, the undersigned, certify that I confirmed all statements 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)