MikroSayang Great Eastern TAKAFUL

CI-09 DOCTOR'S STATEMENT - CRITICAL ILLNESS - TERMINAL ILLNESS

CI-09

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. ____ - ____ - ____

TERMINAL ILLNESS

1. What is the diagnosis? Please describe the full and exact diagnosis of the condition causing patient to be terminally ill.	1. _____
(a) Date of diagnosis:	(a) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
(b) Date when patient / patient's next of kin was informed that the illness was terminal:	(b) ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)
2. How long is the life expectancy of the patient?	2. _____ months
(a) Is the patient's condition incurable and cannot be adequately treated to recover?	(a) ☐ Yes ☐ No
(b) If Yes, please provide your basis.	(b) _____
3. What treatment is the patient currently receiving? Please tick which is applicable.	3. ☐ Transplant Date of transplant ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy) ☐ Chemotherapy/Radiotherapy ☐ Physiotherapy ☐ Palliative care ☐ Medication(s) Please list down all medication prescribed to the patient now.
4. Has the patient previously had the same or similar condition?	4. ☐ 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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