PART II – CERTIFICATE OF MEDICAL ATTENDANCE

1. Patient's Details

Policy No.					
Name of Patient		Occupation			
NRIC No.		Age		Gender	☐ Male ☐ Female

2. Accident Details

a) Date and Time of Accident	Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY	Time : ☐☐☐☐ am/pm
b) Date and Time of First Consultation	Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY	Time : ☐☐☐☐ am/pm

c) How did the accident occur?

_____

_____

3. Injury Details

a) Were there any external and visible injuries as a result of the accident?	☐ Yes ☐ No
b) If yes, describe in detail the extent of injuries sustained as seen by you. Please provide measurement of injury (approximate)	
c) If no, describe any other evidence that is consistent with the accident claimed by patient	
d) In the event of any amputation, please state the site and extent of the amputation level e.g. proximal, middle, distal. *(Please attach diagrams if necessary)*	
e) In the event of any fracture, please state the location and type of fracture	
f) Please state details of POP / Backslab / Immobilization: -	
i. Date POP / Backslab / other immobilization was applied	☐☐ DD ☐☐ MM ☐☐☐☐ YYYY
ii. Date POP / Backslab / other immobilization was removed	☐☐ DD ☐☐ MM ☐☐☐☐ YYYY
iii. Date Physiotherapy started	☐☐ DD ☐☐ MM ☐☐☐☐ YYYY
iv. Date Patient started on full weight bearing	☐☐ DD ☐☐ MM ☐☐☐☐ YYYY
v. Please state the limitation of movement to any joint on the last date of consultation	_____ _____

4. Treatment Details

a) Please provide type of treatment provided including follow-up treatments e.g. no. of stitches, STO, physiotherapy etc.

Date of Treatment	Healing Progress	Treatment / Type of Medication

b) Please describe the condition and function of injured part at last date of consultation

Last Date of Consultation ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY

_____

_____

c) Please explain the healing progress of injury. Please give details of complication of wound healing	☐ Straight Forward ☐ Complicated _____ _____
5. Hospitalization / Diagnostic Procedure Details	
a) Was the patient hospitalized?	☐ Yes ☐ No i) Hospital : _____ ii) Admission Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY iii) Discharge Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY
b) Was surgery performed?	☐ Yes ☐ No Name of surgery : _____
c) Were special Diagnostic Procedure/Treatment conducted or performed?	☐ Yes ☐ No Name of Procedure : _____
6. Other Illness, Disease or Infirmity Suffered	
a) Is or was the patient ever suffering from any illness, disease or infirmity? If yes, please state details and date /onset of diagnosis.	☐ Yes ☐ No _____ _____
b) Was there any evidence of intoxication or drug abuse? If yes, please give details.	☐ Yes ☐ No _____ _____
c) Were there any circumstances such as physical or medical history which may have contributed to the accident and/or prolonged the disability period? If yes, please give details.	☐ Yes ☐ No _____ _____

DECLARATION

I hereby certify that I have personally examined and treated the patient for his/her injuries described above and that the facts as stated above represent my medical findings and opinion of his/her condition.

Name : _____

Address : _____

_____

Date : _____

Signature and Practice Stamp

Important Notice :

- All reports are to be submitted directly in a sealed envelope to the address stated below and stamped **"Private & Confidential".**

  Claims Department : Level 21, Mercu 2, KL Eco City, No. 3, Jalan Bangsar, 59200 Kuala Lumpur.
- Please attach certified true copy of relevant test results or imaging reports available.
- All expenses in procuring this medical report shall be borne by the claimant.