PART II – CERTIFICATE OF MEDICAL ATTENDANCE

Patient's Details			
Policy No.			
Name of Patient		**Age**	
NRIC No.		**Gender**	☐ **Male** ☐ **Female**

Medical Information	
1. Hospitalisation Details **a) Date of Admission / Day Surgery** **b) Date of Discharge**	**a) Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY Time : ☐☐☐☐ am/pm** **b) Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY Time : ☐☐☐☐ am/pm**
2. Was patient referred to you by another doctor? If "Yes", please indicate his/her name, address and provide a copy of referral letter.	☐ **Yes** ☐ **No** **Doctor** __________ **Clinic / Hospital** __________
3. If treatment due to accident, please provide details:- **a) Date and time of Accident** **b) Nature of Accident**	**a) Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY Time : ☐☐☐☐ am/pm** **b)** __________
4. Date you first saw the patient for this injury / illness	**Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY**
5. Please state symptoms which the patient complained of when first saw you for this injury / illness.	
6. How long had the patient been experiencing these symptoms?	☐ **According to patient:** __________ ☐ **In your professional opinion:** __________
7. Has the patient consulted another doctor for the same or similar symptoms as above in the past? If so, please give details.	☐ **Yes** ☐ **No** **Doctor** __________ **Clinic / Hospital** __________
8. Have any investigations, tests or procedures been performed? If Yes", please provide us the details or attach a certified true copy of the results.	☐ **Yes** ☐ **No** __________
9. Please state the diagnosis made.	
10. Please state the underlying cause and pathology.	
11. Date you inform the patient of diagnosis.	**Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY**
12. Nature of medical treatment given / surgery performed **a) Name of Surgeon** **b) Date of Surgery / Operation** **c) MMA OPCS code/ PHFSR code**	**a)** __________ **b) Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY** **c)** __________
13. Is there a possibility of relapse?	☐ **Yes** ☐ **No**

14. Is the condition / treatment in any way related to the following:-

- [ ] pregnancy, and complications thereof, childbirth, abortion, miscarriage, birth control, infertility
- [ ] alcoholism, drug addiction, self-inflicted injuries, suicide or attempted suicide
- [ ] birth defects, including hereditary conditions, and congenital sickness or abnormalities
- [ ] Elective, Cosmetic/ plastic surgery, routine health screening
- [ ] Psychotic / mental disorder which are not organics in nature / anxiety / sleep disorder
- [ ] Venereal disease, AIDS or any other illnesses in the presence of the Human Immuno-deficiency Virus (HIV)
- [ ] Hazardous sports, unlawful act
- [ ] Circumcision, sterilization of either sex, such as castration, vasectomy, and tubectomy

Details: ____

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15. Has the patient been treated or hospitalised in this or any other hospital for this or any other serious disorders? If 'Yes', please give details.

Date	Diagnosis	Details of Treatment / Hospitalization	Doctor's / Hospital's Name & Address

16. Any other information which may help our claims assessment.

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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: ____

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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.