

PART II – CERTIFICATE OF MEDICAL ATTENDANCE

1. Patient's Details						
Policy No.						
Name of Patient				Occupation		
NRIC No.				Age	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
2. Accident Details						
a) Date and Time of Accident	Date : <input type="text"/> DD <input type="text"/> MM <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YYYY			Time : <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> am/pm		
b) Date and Time of First Consultation	Date : <input type="text"/> DD <input type="text"/> MM <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YYYY			Time : <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> am/pm		
c) How did the accident occur?						
<hr/> <hr/>						
3. Injury Details						
a) Were there any external and visible injuries as a result of the accident?				<input type="checkbox"/> Yes <input type="checkbox"/> 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. <i>(Please attach diagrams if necessary)</i>						
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				<input type="text"/> DD <input type="text"/> MM <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YYYY		
ii. Date POP / Backslab / other immobilization was removed				<input type="text"/> DD <input type="text"/> MM <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YYYY		
iii. Date Physiotherapy started				<input type="text"/> DD <input type="text"/> MM <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YYYY		
iv. Date Patient started on full weight bearing				<input type="text"/> DD <input type="text"/> MM <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YYYY		
v. Please state the limitation of movement to any joint on the last date of consultation				<hr/> <hr/>		
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 <input type="text"/> DD <input type="text"/> MM <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YYYY		
<hr/> <hr/>				<hr/> <hr/>		

c) Please explain the healing progress of injury. Please give details of complication of wound healing	<input type="checkbox"/> Straight Forward <input type="checkbox"/> Complicated <hr/> <hr/>
5. Hospitalization / Diagnostic Procedure Details	
a) Was the patient hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No i) Hospital : _____ ii) Admission Date : <input type="text"/> <input type="text"/> DD <input type="text"/> <input type="text"/> MM <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YYYY iii) Discharge Date : <input type="text"/> <input type="text"/> DD <input type="text"/> <input type="text"/> MM <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> YYYY
b) Was surgery performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No Name of surgery : _____
c) Were special Diagnostic Procedure/Treatment conducted or performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No Name of Procedure : _____
6. Other Illness, Disease or Infirmary 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> <hr/>
b) Was there any evidence of intoxication or drug abuse? If yes, please give details.	<input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> <hr/>
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.	<input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> <hr/>

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.