FWD takaful

PART II – ATTENDING PHYSICIAN'S STATEMENT (STATEMENT OF CRITICAL ILLNESS)

BLINDNESS / LOSS OF HEARING / DEAFNESS / LOSS OF SPEECH

This report is to be completed by a registered medical practitioner at the own expense of claimant.

Name of Patient			
Age		NRIC	
Present Occupation		Gender	☐ Male / ☐ Female

Please tick (√) in the relevant box		Sections to be completed
	Blindness	1, 2, 3, 6, 7, 8 & 9
	Loss of Hearing / Deafness	1, 2, 4, 6, 7, 8 & 9
	Loss of Speech	1, 2, 5, 6, 7, 8 & 9

1. General Details	
a) Are you the patient's regular medical attendant?	☐ Yes ☐ No
b) When did your patient first consult you for this condition?	
c) Symptoms presented at that time	
d) Date of symptoms first appeared	According to patient :_____ In your opinion :_____
e) Please describe the exact details of your patient's present condition.	
f) Date last seen by you	

2. Diagnosis Details	
a) Please give full details of the diagnosis.	
b) Date of diagnosis	
c) Name and address of doctor who established the diagnosis	

d) Was your patient informed of the diagnosis? If yes, when and by whom?	
e) Had your patient suffered any previous episodes of this condition or any other conditions leading to it or relating to it? If yes, please give details, including exact date of episodes or conditions.	
f) Was your patient referred to you? If yes, please give name and address of doctor concerned.	
g) Name and address of doctor(s) who attended to your patient prior seeing to you	
h) Name and address of doctor(s) who is/are treating your patient concurrently for this condition	
i) Did you refer your patient to any other doctor(s)? If yes, please provide name and address of the doctor(s).	

3. Please complete the section below if your patient was diagnosed to have Blindness.		
a) Is there a <u>total</u> loss of vision of both eyes?	☐ Yes. Since when :	☐ No
b) What is the underlying cause of loss of vision?		
c) Is there a possibility of any vision to be restored/corrected with appropriate treatment or surgery? If yes, please provide us the details. If no, is the loss of vision permanent?	Right eye:	Left eye:
d) What is the latest visual acuity of the right and left eye (aided and unaided)?		

4. Please complete the section below if your patient was diagnosed to have Loss of Hearing / Deafness.		
a) Is there a total loss of hearing of both ears?	☐ Yes	☐ No
b) What is the underlying cause of loss of hearing?		
c) Please advise degree of hearing loss (in decibels) of right and left ear	Right ear:	Left ear:

d) Is there a possibility of hearing loss to be corrected with hearing aids or other appropriate treatment or surgery? If yes, please provide us the details. If no, is the loss of hearing permanent?	☐ Yes Details : ☐ No
e) Any audiometry and sound threshold tests done? If yes, please provide us the details of all the results	☐ Yes Details : ☐ No

5. Please complete the section below if your patient was diagnosed to have Loss of Speech.	
a) Is there a total loss of speech?	☐ Yes ☐ No
b) What is the underlying cause of loss of speech?	
c) Was the patient suffer from loss of speech for a continuous period of six (6) months or above? If yes, since when?	☐ Yes Since when : ☐ No
d) Is there a possibility of loss of speech to be corrected with appropriate treatment or surgery? If yes, please provide us the details. If no, is the loss of speech permanent?	☐ Yes Details : ☐ No

6. Is there any possibility of a surgical procedure or any other form of corrective treatment? If yes, please give details.

7. Have any other investigation tests or procedures been performed? If yes, please provide us the details and enclose a copy of the report.

8. Has the patient been treated for any of the following illnesses? If yes, please provide additional information as per the table below.			
	Date of diagnosis/ Onset	Name and address of Doctor(s) consulted	Dates of consultation

Hypertension			
Diabetes Mellitus			
Cardiovascular Diseases			
Other illnesses/ Injuries Please specify			

9. Please give other information which you feel would be helpful in the assessment of your patient's claim.

Note: Please enclose copies of all investigation reports including biopsy, cytology reports, CT Scans, imaging studies, laboratory evidence, surgical reports and all other relevant hospital reports that are available.

I hereby certify that I *have / have not seen the claimant's Identity Card number as stated above and that the photograph of which bears resemblance to the claimant whom I have examined.

I hereby certify that the answers above are full, complete and true.

_____
(Signature of Doctor)

Name : _____

Qualification : _____

Date : _____

Official Hospital Stamp: