HongLeong Assurance

C012513030

Policy No. : _____ Claim No. : _____

MEDICAL ATTENDANT'S REPORT ON HOSPITALISATION BENEFIT / HOSPITAL INCOME / HOSPITAL & SURGICAL / PERSONAL ACCIDENT / DISMEMBERMENT CLAIM

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

1. a) Name of Patient.	
b) I/C No.	
c) Date of Birth.	Date: (dd/mm/yyyy)
d) Present Occupation. (If more than one, please state all)	
2. a) Admission date and time.	Date: (dd/mm/yyyy) Time: (am/pm)
b) Discharge date and time.	Date: (dd/mm/yyyy) Time: (am/pm)
3. a) Final diagnosis.	
b) Date first diagnosed and by which doctor.	Date: (dd/mm/yyyy) Doctor:
c) Was your patient informed of the diagnosis? If yes, when and by whom?	Yes ☐ Doctor's name : Date : (dd/mm/yyyy) No ☐
d) When did your patient first consult you for the condition?	Date: (dd/mm/yyyy)
e) Symptoms presented at first consultation.	
f) Date of symptoms first appeared prior to first consultation.	Date: (dd/mm/yyyy)
4. Cause and pathology of the diagnosis.	
5. How did you confirm the diagnosis? Kindly enclose a copy of the report(s).	
6. a) Name and address of referral doctors.	
b) Name and address of other doctors attended to patient for the diagnosis.	
7. Can the treatment be managed on outpatient basis? Please elaborate.	Yes ☐ Details: No ☐
8. Type of treatment given for the diagnosis.	
9. a) Date of surgery performed for the diagnosis.	Date: (dd/mm/yyyy)
b) Type of surgery performed for the diagnosis.	
10. If the condition was due to an accident, please state: a) Date and time of accident. b) Full circumstances of accident.	a) Date: (dd/mm/yyyy) Time: (am/pm) b)
c) Were there any external and visible injuries seen as a result of the accident? If yes, please describe the nature and extent of injuries including site and other characteristic features.	Yes ☐ Details: No ☐
d) In your opinion, is it certain that these injuries resulted directly from the accident? Please elaborate.	Yes ☐ Details: No ☐

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e) Date and time of each consultation for the injury, details of treatment rendered and healing progress. (If the columns given is inadequate, please fill up in another sheet)

Date (dd/mm/yyyy) and time (am/pm)	Treatment rendered and healing progress

f) Last consultation date and patient's injury condition.	Date:	(dd/mm/yyyy)	Condition:	
g) If the patient was immobilized , please provide following information:				
i. Type of immobilization.				
ii. Date it was applied and removed.	Applied: :	(dd/mm/yyyy)	Removed:	(dd/mm/yyyy)
iii.Date patient started full weight bearing.	Date:			(dd/mm/yyyy)
h) Was the healing of the injuries complicated? Please elaborate.	Yes ☐	Details:		No ☐

11. For Dismemberment Claim Only

a) Please give full details of disability.				
b) Is the patient's condition / disability expected to be permanent and resulting in total loss of use? Please elaborate.	Yes ☐	Details:		No ☐
c) Is there any possibility of surgical or any other form of corrective treatment? If yes, please provide details.	Yes ☐	Details:		No ☐

12. Had 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 (dd/mm/yyyy)	Name & address of Doctor(s) consulted	Dates of Consultation (dd/mm/yyyy)
a) Hypertension			
b) Diabetes Mellitus			
c) Cardiovascular Disease			
d) Other illnesses / injuries Please specify : i.	i.	i.	i.
ii.	ii.	ii.	ii.

13. Was the patient's current condition caused by / contributed directly or indirectly by?

a) Congenital abnormality / hereditary condition	Yes ☐	No ☐	e) HIV or AIDS related complex	Yes ☐	No ☐
b) Psychotic / mental or nervous disorders	Yes ☐	No ☐	f) Childbirth / pregnancy / miscarriage	Yes ☐	No ☐
c) Venereal disease	Yes ☐	No ☐	g) Influence of alcohol / drugs	Yes ☐	No ☐
d) Self-inflicted injury / attempted suicide	Yes ☐	No ☐	h) Degeneration of bone	Yes ☐	No ☐

14. Was the patient's current condition developed within six (6) months from the date of birth?	Yes ☐	No ☐	Details:
15. Please provide any further information which may be of assistance to us in assessing the claim.			

Signature: _____

Name (in block capitals please): _____

Qualification: _____

Contact No.: _____

Date: _____(dd/mm/yyyy)

Official Stamp: