HongLeong Assurance

C014917070

Policy No. : _____ Claim No. : _____

MEDICAL ATTENDANT'S REPORT ON OUTPATIENT TREATMENT FOR DENGUE / ZIKA

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. (dd/mm/yyyy)	
d) Present Occupation. (If more than one, please state all)	
2. a) Are you the patient's usual medical doctor?	Yes ☐ Over what period do your records extend : No ☐ From: _____(dd/mm/yyyy) to _____(dd/mm/yyyy)
b) Date that the patient first consulted you for the condition? (dd/mm/yyyy)	
3. a) Final Diagnosis.	
b) Date of the diagnosis was made? (dd/mm/yyyy)	
c) Date that the patient was told of the diagnosis? (dd/mm/yyyy)	

d) Was there presence of the following symptoms and how long had he/she been experiencing these symptoms?

Symptoms	Please Tick		Date Symptoms First Started (dd/mm/yyyy) / Duration
Fever	Yes ☐	No ☐	/
Severe headache	Yes ☐	No ☐	/
Pain behind the eyes	Yes ☐	No ☐	/
Muscle and joint pains	Yes ☐	No ☐	/
Conjunctivitis	Yes ☐	No ☐	/
Nausea	Yes ☐	No ☐	/
Vomiting	Yes ☐	No ☐	/
Swollen glands	Yes ☐	No ☐	/
Diffuse maculopapular rash	Yes ☐	No ☐	/

4. Name and address of other doctors attended to patient for these symptoms(s).

Name of Doctor	Name of Clinic / Hospital and Address

5. Please enclose copies of confirmatory serologic testing (RT-PCR) or positive isolation of relevant virus, all laboratory evidences, and any other relevant hospital reports that are available.

6. 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. ii.	i. ii.	i. ii.	i. ii.

7. 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: