PRUDENTIAL BSN TAKAFUL

CONGENITAL CONDITION CLAIM – DOCTOR'S STATEMENT

Note: This form is to be completed at the Patient's expenses by the Attending Doctor.

Patient's Personal Details

Name: _____

Certificate Number: _____

NRIC/Old IC/Passport/Birth Cert/Other: _____

Date of Birth: _____

Gender: ____ Male ____ Female

The claim is being filled for the following illness: (Please tick [√] in the appropriate box)

Sections to be completed:

___ Cerebral Palsy	A, B & L
___ Cleft Lip and/or Cleft Palate	A, C & L
___ Coarctation of the Aorta	A, D & L
___ Congenital Cataract	A, E & L
___ Oesophageal Atresia	A, F & L
___ Retinopathy of Prematurity	A, C & L
___ Tracheo-oesophageal Fistula	A, D & L
___ Atrial Septal Defect	A, C & L
___ Ventricular Septal Defect	A, C & L

Sections to be completed:

___ Anal Atresia	A, D & L
___ Congenital Deafness	A, E & L
___ Congenital Diaphragmatic Hernia	A, F & L
___ Down's Syndrome	A, G & L
___ Infantile Hydrocephalus	A, H & L
___ spina Bifida	A, I & L
___ Tetralogy of Fallot	A, J & L
___ Transposition of the Great Vessels	A, K & L

SECTION A: Medical Record of The Patient

1. Please advise what is the exact full diagnosis.

2. Are you the patient's usual Medical Attendant?
   ___YES ___NO

3. Over what period do your record extend?
   a) First consultation ____Day _____Month _____Year
   b) Last consultation ____Day _____Month _____Year

4. What were the symptoms presented when you first attended the patient? How long has the patient been experiencing the symptoms when you first saw the patient?

Symptom(s)	Duration of Symptom(s)

5. Date when the guardian/parents of the patient first been made aware of the condition.
   ____Day _____Month _____Year

6. Please describe what is the exact full diagnosis.

Diagnosis	Diagnosis Date (DD/MM/YYYY)

7. Date when the guardian/parents of the patient was/were informed of the diagnosis.
   ____Day _____Month _____Year

8. Name and the practice of doctor(s) who first diagnosed the patient.

9. Please provide the dates and other details of investigations performed.

Date (DD/MM/YYYY)	Test/Laboratory/Imaging

10. Is the diagnosis related to any of the following? (Please tick [√] and circle the relevant option)
___Pregnancy resulting from fertility treatment, including in-vitro fertilization
___Chosen to have a termination of pregnancy other than for medical reasons
___Alcohol or Substance Abuse/Addition
___AIDS/HIV Positive
___Violation of laws/Strike/Riots

SECTION B:
- Cerebral Palsy
- Cleft Lip and/or Cleft Plate
- Coarctation of the Aorta
- Congenital Cataract
- Oesophageal Atresia
- Retinopathy of Prematurity
- Tracheo-oesophageal Fistula

1. Was there any procedure/surgery performed for the congenital condition?
___YES, kindly provide the date of surgery. ____Day _____ Month _____ Year
___NO
2. Please specify the type of procedure/surgery done.
3. Name of the surgeon and the specialty.
4. Please enclose copies of all report, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, and/or any other relevant hospital reports that are available.

SECTION C:
- Atrial Septal Defect
- Ventricular Septal Defect

1. Does the patient's condition warrant surgical closure for the reversal of haemodynamic abnormalities and the prevention of heart failure, paradoxic embolism or irreversible pulmonary vascular disease?
___YES ___NO
2. The date on which the surgical closure is scheduled to be performed:
____Day _____Month _____Year
3. What are the further procedures or surgeries planned?
4. Please provide details of the patient's current condition.
5. Please enclose copies of all report, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, and/or any other relevant hospital reports that are available.

SECTION D: Anal Atresia

1. Does the patient have high imperforated anus needing colostomy?
___YES ___NO
2. Was there any procedure/surgery performed for the congenital condition?
___YES, kindly provide the date of surgery. ____Day _____ Month _____ Year
___NO

3. Kindly specify the type of procedure/surgery done.

4. Name of surgeon and the specialty.

5. Please enclose copies of all report, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, and/or any other relevant hospital reports that are available.

SECTION E: Congenital Deafness

1. Did the patient suffer for loss of hearing of both ears present at birth?
   ___YES ___NO
2. Was there any immediate admission to a hospital required for the treatment of the congenital deafness?
   ___YES, kindly provide the date of admission. ____Day _____ Month _____ Year
   ___NO
3. What was the treatment given?
4. Name of doctor and the specialty.
5. Please enclose copies of all report, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, and/or any other relevant hospital reports that are available.

SECTION F: Congenital Diaphragmatic Hernia

1. Was there any presence of abdominal organs in the chest cavity at birth?
   ___YES ___NO
2. Was the condition associated with pulmonary hypoplasia or an underdeveloped heart?
   ___YES ___NO
3. Please enclose copies of all report, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, and/or any other relevant hospital reports that are available.

SECTION G: Down's Syndrome

1. Is there an extra chromosome 21 detected?
   ___YES, kindly furnish a copy of the results confirming the presence of an extra chromosome 21.
   ___NO
2. Does the patient exhibit medical indication as listed below?
   a) Muscular hypotonicity ___YES ___NO
   b) Microcephaly ___YES ___NO
   c) Brachycephaly ___YES ___NO
   d) Flattened occiput ___YES ___NO

3. What is the nature extent of hindrance of physical and mental development?

SECTION H: Infantile Hydrocephalus

1. Does the patient have enlargement of the cerebrospinal fluid spaces resulting from obstruction of flow pathway between the secretion sites in the ventricles and absorption sites in the subarachnoid space?
   ___YES ___NO
2. Is the patient's condition serious enough to warrant the placement of a shunt?
   ___YES ___NO
3. The date on which the surgery is scheduled to be performed.
   ____Day _____Month _____Year
4. What are the further procedures or surgeries planned?
5. Please give details of the patient's current condition.
6. Please enclose copies of all report, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, and/or any other relevant hospital reports that are available.

SECTION I: Spina Bifida

1. Please describe the extent of the defective closure of the spinal column due to a neural tube defect.
2. Did the patient's Spinal Bifida resulted from meningomyelocele or meningocele?
   ___YES ___NO

If Yes, please specify.

3. Is the condition associated with neurological deficit?
   ___YES ___NO

If Yes, please specify.

4. Please enclose copies of all report, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, and/or any other relevant hospital reports that are available.

SECTION J: Tetralogy of Fallot

1. Does the patient has any of the anatomic abnormality listed below?

a)	Severe or total obstruction of right ventricular outflow tract	___YES	___NO
b)	Ventricular septal defect	___YES	___NO
c)	Dextroposition of the aorta with septal override	___YES	___NO
d)	Right ventricular hypertrophy as confirmed by an echocardiogram	___YES	___NO

2. Please enclose copies of all report, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, and/or any other relevant hospital reports that are available.

SECTION K: Transposition of the Great Vessels

1. Does the patient have complete transposition of the aorta and pulmonary artery?
   ___YES ___NO
2. Is the above condition associated with any of the items listed below?
   a) Right ventricle pump blood from the systemic veins into the aorta? ___YES ___NO
   b) Left ventricle pump blood from the pulmonary veins into the pulmonary artery? ___YES ___NO
3. Please enclose copies of all report, radiological procedures, CT scanning, laboratory evidence, other imaging procedure, and/or any other relevant hospital reports that are available.

SECTION L: Attending Doctor's Declaration

I hereby certify that:

___ I am the patient's attending doctor and I have personally examined and treated the patient for the illness/injuries sustained; OR

___ I have personally perused the patient's medical records;

and that the facts as stated above are all true to the best of my knowledge and information that I have perused.

If you are not the attending doctor, please state, the Attending Doctor's Name & Specialty:

The reason(s) for completing this document on behalf of the Attending Doctor:

Signature :

Date :
Name :
Professional Qualification :
MMC/Registration Number :
Name & Address of Hospital/Clinic :
Official Stamp of the Hospital/Doctor :