PRUDENTIAL BSN TAKAFUL

PAEDIATRICIAN– 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

SECTION A: Medical History of The Patient

1. Hospitalisation

   Admission Date: ___Day ___ Month ___ Year
   Discharge Date : ___Day ___ Month ___ Year

   ICU/HDU (if applicable)

   From : ___Day ___ Month ___ Year
   To : ___Day ___ Month ___ Year

   Incubation (if applicable)

   From : ___Day ___ Month ___ Year
   To : ___Day ___ Month ___ Year

2. Was the patient born prematurely?
   ___YES ___NO

If Yes, please state the gestational period and circle the applicable term.

	Weeks /Months

3. Presenting signs and symptoms (including the duration):

4. The following records upon the admission:

a) Blood Pressure		mmHg
b) Temperature		°C
c) Pulse		Beat per minute

5. Final diagnosis.

6. Is the final diagnosis related to any of the following? (Please indicate [√] or circle the relevant)
   ___Alcohol or substance Abuse/Addiction of the baby's mother
   ___Complication resulting from fertility including in vitro fertilization
   ___Baby's mother has AIDS/is HIV positive
   ___Suicide or attempted suicide while sane or insane/Self-inflicted injuries of the baby's mother

7. Was the patient referred to you?
   ___YES ___NO

If Yes, please enclose a copy of the referral letter (if any) and answer the following questions:

a) Name of referred doctor/clinic.

b) Address of the clinic.

Prudential BSN Takaful Berhad (Company number: 200601020898)
Level 13, Menara Prudential, Persiaran TRX Barat, 55188 Tun Razak Exchange, Kuala Lumpur.
P.O. Box 10073, 50704 Kuala Lumpur.
General: +603 2778 3888 I Customer Service Hotline: 03 2053 7188
E-mail: customer@prubsn.com.my I Website: www.prubsn.com.my

8. Has the patient been hospitalised for the same illness whether in this hospital or at any other hospital?
___YES ___NO

If Yes, please state details of previous admission as below:

Date of admission (DD/MM/YYYY)	Hospital	Diagnosis/Illness	Treatment

9. Is the patient suffering from any other underlying illness besides the current medical condition?
___YES ___NO

If Yes, please state details of previous admission as below:

Date of Diagnosis (DD/MM/YYYY)	Underlying Illness	Doctor's Name/Address/Telephone No

10. Please state all investigations, tests or procedures which had been performed. Please attach a copy of all the test results.
___YES ___NO

If Yes, please state details of previous admission as below:

Date (DD/MM/YYYY)	Underlying Illness	Doctor's Name/Address/Telephone No

11. Nature of treatment given and date (DD/MM/YYYY)
___YES ___NO

If Yes, please state details of previous admission as below:

Date (DD/MM/YYYY)	Nature of Treatment

12. Details of surgery:
___YES ___NO

If Yes, please state details of previous admission as below:

Date of Surgery Performed (DD/MM/YYYY)	Nature of Operation Performed	Name of Surgeon	Type of Implant (if any)

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SECTION B: 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.

Signature :

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