PRUDENTIAL BSN
TAKAFUL

INFECTIOUS DISEASE BENEFIT 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

SECTION A: Medical History of The Patient

1. Please select the infectious disease the patient is suffering from:

___Zika Virus
___MERS-CoV
___Ebola
___SARS
___Influenza A-Avian Influenza
___Nipah Virus Encephalitis
___Japanese Encephalitis
___Creutzfeldt-Jakob Disease
___Malaria
___Measles
___Hand Foot Mouth Disease
___Chikungunya Fever
___Typhoid Fever
___Rabies

2. Please describe in full the exact diagnosis.

____

3. Are you the patient's regular/family doctor?
___YES, please state the date of the patient's first visit to you/your clinic. ____Day ______ Month ______ Year
___NO

4. Date when the patient first consulted you for this condition.
____Day ______Month ______Year

5. The presenting signs, symptoms and severity during the first consultation with you.

6. The date when the patient first noticed the presenting sign and symptoms.
____Day ______Month ______Year

7. In your opinion, how long has the presenting signs and symptoms lasted prior to the first consultation with you?
____Day ______Month ______Year

8. Date of diagnosis.
____Day ______Month ______Year

9. Date when the patient was informed of the diagnosis.
____Day ______Month ______Year

10. Please state all investigations or tests which had been performed on the patient.

Date (DD/MM/YYYY)	Test/Laboratory/Procedure	Investigation Outcome/Test Result

11. Was the patient hospitalised for the above condition?
___YES ___NO

If Yes, please provide hospitalisation details:

a) Admission Date & Time: ____Day ______Month ______Year ______am/pm
b) Discharges Date & Time: ____Day ______Month ______Year ______am/pm

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12. Please state details and nature of the treatment/medication given to the patient.

Date (DD/MM/YYYY)	Treatment /Medication

13. Please provide full and exact details of the following:
a) Complications associated to the diagnosis.

b) If the diagnosis is Measles, please confirm if the condition has resulted in any one of the following complications:
i) Pneumonia ___YES ___NO
ii) Encephalitis ___YES ___NO
iii) Singular Convulsions ___YES ___NO
iv) Hepatitis ___YES ___NO

c) If the diagnosis is Hand Foot Mouth Disease, please confirm if the condition has resulted any one of the following complications:
i) Encephalitis ___YES ___NO
ii) Myocarditis ___YES ___NO
iii) Evidence of neurological deficit at least 30 days after the diagnosis ___YES ___NO

d) If the diagnosis is Chikungunya Fever, please confirm if the condition has resulted in one of the following complications:
i) Myocarditis ___YES ___NO
ii) Ocular disease (Uveitis, Retinitis) ___YES ___NO
iii) Hepatitis ___YES ___NO
iv) Severe Bullous Lesions ___YES ___NO
v) Meningoencephalitis ___YES ___NO
vi) Guillain-Barre syndrome ___YES ___NO
vii) Myelitis ___YES ___NO
viii) Cranial nerve palsies ___YES ___NO

e) If the diagnosis is Typhoid Fever, please confirm if the condition has resulted in one of the following complications:
i) Internal bleeding ___YES ___NO
ii) Intestinal Perforation ___YES ___NO
iii) Severe Neuropsychiatric symptoms namely Delirium or Psychosis ___YES ___NO

f) If the diagnosis is Influenza A – Avian Influenza, please confirm the below:
i) Avian Influenza confirmed with the positive isolation of A(H7N9) or A(H5N1) ___YES ___NO
ii) Tested using viral isolation OR rRT-PCR, OR immunofluorescence antibody-IFA ___YES ___NO
iii) Requiring hospitalization for at least twenty-four (24) hours ___YES ___NO

14. Which of the following factors are present? For factors which are present, please provide the date of onset.
i) Internal bleeding ___YES ___NO ____Day ______ Month ______Year
ii) Diabetes Mellitus ___YES ___NO ____Day ______ Month ______Year
iii) Hyperlipidemia ___YES ___NO ____Day ______ Month ______Year
iv) Others, please specify

____Day ______Month ______Year

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15. Has the patient previously been treated/hospitalised whether in this hospital or any other medical/healthcare facilities for this or related illness/conditions or any other disorder?
___YES ___NO

If Yes, please provide details as required below:

Date of Consultation (DD/MM/YYYY)	Illness/Diagnosis	Type of Treatment Received/ Details of Hospitalisation	Name of Doctor & Name of Hospital/ Medical or Healthcare Facilities

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

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 :

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