PART II – CERTIFICATE OF MEDICAL ATTENDANCE

Patient's Details			
Policy No.			
Name of Patient		Age	
NRIC No.		Gender	☐ Male ☐ Female

Medical Information	
1. Hospitalisation Details a) Date of Admission / Day Surgery b) Date of Discharge	a) Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY Time : ☐☐☐☐ am/pm b) Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY Time : ☐☐☐☐ am/pm
2. Was patient referred to you by another doctor? If "Yes", please indicate his/her name, address and provide a copy of referral letter.	☐ Yes ☐ No Doctor _____ Clinic / Hospital _____
3. If treatment due to accident, please provide details:- a) Date and time of Accident b) Nature of Accident	a) Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY Time : ☐☐☐☐ am/pm b) _____
4. Date you first saw the patient for this injury / illness	Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY
5. Please state symptoms which the patient complained of when first saw you for this injury / illness.	
6. How long had the patient been experiencing these symptoms?	☐ According to patient: _____ ☐ In your professional opinion: _____
7. Has the patient consulted another doctor for the same or similar symptoms as above in the past? If so, please give details.	☐ Yes ☐ No Doctor _____ Clinic / Hospital _____
8. Have any investigations, tests or procedures been performed? If Yes", please provide us the details or attach a certified true copy of the results.	☐ Yes ☐ No _____
9. Please state the diagnosis made.	
10. Please state the underlying cause and pathology.	
11. Date you first saw the patient for this injury / illness	Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY
12. Nature of medical treatment given / surgery performed a) Name of Surgeon b) Date of Discharge c) MMA OPCS code/ PHFSR code	a) _____ b) Date : ☐☐ DD ☐☐ MM ☐☐☐☐ YYYY c) _____
13. Is there a possibility of relapse?	☐ Yes ☐ No

14. Is the condition / treatment in any way related to the following:-

- ☐ pregnancy, and complications thereof, childbirth, abortion, miscarriage, birth control, infertility
- ☐ alcoholism, drug addiction, self-inflicted injuries, suicide or attempted suicide
- ☐ birth defects, including hereditary conditions, and congenital sickness or abnormalities
- ☐ Elective, Cosmetic/ plastic surgery, routine health screening
- ☐ Psychotic / mental disorder which are not organics in nature / anxiety / sleep disorder
- ☐ Venereal disease, AIDS or any other illnesses in the presence of the Human Immuno-deficiency Virus (HIV)
- ☐ Hazardous sports, unlawful act
- ☐ Circumcision, sterilization of either sex, such as castration, vasectomy, and tubectomy

Details: _____

_____

15. Has the patient been treated or hospitalised in this or any other hospital for this or any other serious disorders? If 'Yes', please give details.

Date	Diagnosis	Details of Treatment / Hospitalization	Doctor's / Hospital's Name & Address

16. Any other information which may help our claims assessment.

_____

_____

I hereby certify that I have personally examined and treated the patient for his/her injuries described above and that the facts as stated above represent my medical findings and opinion of his/her condition.

Name : _____

Address : _____

_____

Date : _____

Signature and Practice Stamp

Important Notice :

- All reports are to be submitted directly in a sealed envelope to the address stated below and stamped **"Private & Confidential".**

  Claims Department: Level 21, Mercu 2, KL Eco City, No. 3 Jalan Bangsar, 59200 Kuala Lumpur.
- Please attach certified true copy of relevant test results or imaging reports available.
- All expenses in procuring this medical report shall be borne by the claimant.