eTiQa Takaful

HOSPITALISATION BENEFIT (HB) - STATEMENT OF MEDICAL EXAMINER

SECTION B

1. Section B of this form is to be completed by a legally qualified and registered medical practitioner who has treated the Participant.
2. Expenses incurred to obtain this report will be borne by the Participant.

Contract No: ……..

1. Name of Patient: ……..
2. NRIC No. : ……..... BC / Old IC No. : …….. Age: ……..
3. Date of Admission: ……..(dd/mm/yyyy) Time : ……...(am/pm)
4. Date of Discharge: ……..(dd/mm/yyyy) Time : ……...(am/pm)
5. Diagnosis: ……..
6. Date of diagnosis: ……...(dd/mm/yyyy)
7. What was the underlying cause and pathology of the above diagnosis?

   ……
8. Did you inform the patient of the diagnosis, if so, when? …….. (dd/mm/yyyy)
9. When you **first** saw the patient for this illness/ condition …….. (dd/mm/yyyy)
10. Have any investigations, tests or procedures been performed? ☐ Yes ☐ No
    i. If so, what were the results?……
    ii. Please furnish a certified true copy of the results
11. Was the patient referred to you by any doctor? ☐ Yes ☐ No
    i. If yes, please indicate the name of doctor and address of the clinic / hospital.

       ……
    ii. Please attach a copy of the referral letter, if any.
12. Who was the doctor who **first** diagnosed the patient for this illness? Please provide name and address of the doctor

    ……..
13. According to the patient:
    i. What were the symptoms complained? ……
    ii. How long had he/she been experiencing these symptoms? ……..
    iii. Did the patient already know or aware he/she has this diagnosis before the **first** consultation with you? ☐ Yes ☐ No
       a. Since when? …… (dd/mm/yyyy)
    iv. Has the patient previously received any treatment for the above symptom/diagnosis? ☐ Yes ☐ No
       a. If yes, please furnish name and address of the doctor

          ……
       b. Date of last treatment the patient received before **first** consultation with you: ……(dd/mm/yyyy)
       c. Type of treatments the patient received upon **first** diagnosed of this illness: .....

          ……
14. Was the condition ☐ Congenital ☐ Hereditary ☐ Alcohol ☐ Nervous
    ☐ AIDS/HIV ☐ Drug Abuse ☐ Cosmetic ☐ Mental ☐ Sexually Transmitted Disease

15. Any surgery/procedure performed? ☐ Yes ☐ No

i. If yes, please state type of surgery/procedure performed

Type of surgery/procedure	Date (dd/mm/yyyy)	Name of Doctor & Hospital

16. Nature of medical treatment given ……..

17. Any possibility of relapse? ☐ Yes ☐ No

18. Has the patient previously been treated or hospitalized in this hospital or other hospital for **any other disease**? ☐ Yes ☐ No

i. If yes, please state

Date (dd/mm/yyyy)	Diagnosis	Name of Doctor & Hospital

19. If the patient was diagnosed to have High Blood Pressure and / or Diabetes, please state the recorded blood pressure or diabetes taken on him/ her starting from the **first** recording done :

Date (dd/mm/yyyy)	**Readings of Blood Pressure**	**Date (dd/mm/yyyy)**	**Results for Blood Glucose (Fasting)**
i. ……	……..	i. ……	……..
ii. ……	……..	ii. ……	……..
iii. ……	……..	iii. ……	……..

20. **For female only** - was the patient pregnant at the time of hospitalisation? ☐ Yes ☐ No

i. If so, for how many weeks? ……

ii. Was illness caused directly or indirectly by pregnancy / child birth / caesarian / abortion / miscarriage / infertility and all complications arising therefrom? ☐ Yes ☐ No

If yes, please elaborate : ……

DECLARATION

I hereby declare that the foregoing answers and statements are complete and true to the best of my knowledge and belief and that I have withheld no material fact from the Company. I also hereby certify that the above information is correct as per record from the hospital / clinic.

Signature of Doctor : _____

Name of Doctor : _____ Qualification : _____

Telephone No. : _____ Fax No. : _____

Date : _____(dd/mm/yyyy)

Official Stamp of Doctor : Name and Address of Clinic / Hospital Official Stamp

_____ _____

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