



# CRITICAL ILLNESS – BRAIN AND NERVE RELATED (BY DOCTOR)

**Important Note :**

Your patient is insured with us against the happening of certain contingent events associated with his or her health. To enable us to assess the claim, please complete this report with as much details as you can possibly provide. Your kind assistance will help expedite the claim settlement.

(For any medical report fee incurred in completing this form, it will be borne by the claimant)

Policy No

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## 1. Patient's details

Full Name

NRIC / OLD IC / Passport No.

Occupation & exact duties

Please attach the certified true copy of all the relevant tests available.

- CT Scan / MRI of the brain
- MRI of Spine
- Lumbar puncture test report
- Nerve conduction report
- Evoked Potential Test
- Blood Test Report
- Surgery Report
- Histopathology Report (HPE)
- Biopsy Report
- Other Report :

## 2. Medical Record

Are you the patient's regular doctor?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, since when? <input type="text"/> <input type="text"/> DD <input type="text"/> <input type="text"/> MM <input type="text"/> <input type="text"/> YY	
Date the patient <b>FIRST</b> consulted you for the ILLNESS <input type="text"/> <input type="text"/> DD <input type="text"/> <input type="text"/> MM <input type="text"/> <input type="text"/> YY	Please state the symptom presented during the FIRST consultation		
	<b>Symptoms</b>	<b>Date symptom FIRST presented? (dd/mm/yy)</b>	
	<input type="text"/>	<input type="text"/>	
Please describe FULL and EXACT diagnosis.		Date when ILLNESS was FIRST diagnosed <input type="text"/> <input type="text"/> DD <input type="text"/> <input type="text"/> MM <input type="text"/> <input type="text"/> YY	
Diagnosis was FIRST made by (Name of Doctor & Hospital)		Date when patient FIRST became aware of the illness <input type="text"/> <input type="text"/> DD <input type="text"/> <input type="text"/> MM <input type="text"/> <input type="text"/> YY	
Which of the following factors are present? Please provide the date of onset			
<b>Factors</b>	<b>YES</b>	<b>NO</b>	<b>Date of onset (dd/mm/yy)</b>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Hyperlipidemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Others, please specify :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
What is the source of information :			
<input type="checkbox"/>	Patient		
<input type="checkbox"/>	Referring doctor. Name of doctor & hospital / clinic : _____		
<input type="checkbox"/>	Others, please specify : _____		





<input type="checkbox"/> Coma	<p>Date and time of onset <input type="text"/> DD <input type="text"/> MM <input type="text"/> YY <input type="text"/> am / pm</p> <p>Was the patient put on life support system? <input type="checkbox"/> Yes <input type="checkbox"/> No          If yes, for how long? <input type="text"/> Hours</p> <p>Was the coma 'Medically induced'? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What is the extent of come under the Glasgow Coma Scale (GCS) or any other measurement for coma?          Please state type of measurement.</p> <input type="text"/>
<input type="checkbox"/> Major Head Trauma	<p>Is the coma resulting from any of the following?</p> <p>Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Drug abuse / misuse <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Self-inflicted injury <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Medically induced <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<input type="checkbox"/> Multiple Sclerosis	<p>Is there any injury to the brain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Was there any fracture of the skull bones? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Was a surgery performed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please provide details of circumstances where the leading to injury.</p> <input type="text"/>
<input type="checkbox"/> Motor Neuron Disease	<p>Types of Motor Neuron Disease</p> <p><input type="checkbox"/> Amyotrophic lateral sclerosis <input type="checkbox"/> Primary lateral sclerosis</p> <p><input type="checkbox"/> Progressive bulbar palsy <input type="checkbox"/> Spinal muscular atrophy</p>
<input type="checkbox"/> Muscular Dystrophy	<p>Types of Muscular Dystrophy</p> <p><input type="checkbox"/> Duchenne's <input type="checkbox"/> Myotonic</p> <p><input type="checkbox"/> Facioscapulohumeral <input type="checkbox"/> Congenital</p> <p><input type="checkbox"/> Others :</p>





General examination findings :	
Are there any abnormal movements or abnormal gait? Please provide full details.	_____
Is there any muscle wasting? Please provide full details.	_____
Is there any other significant examination findings? Please provide full details.	_____

Examination of the Limbs:  
Please indicate the **muscle power** of the various joint in the table below with maximum **grade of 5**

Upper Limbs	Right	Left
Shoulder		
Elbow		
Wrist		
Grip		
Lower Limbs	Right	Left
Hip		
Knee		
Ankle		

Assessment of Activities Daily Living			
Activities of Daily Living	Not Limited	Limited	Incapable
<b>Transfer</b> Getting in & out of a chair without physical assistance			
<b>Mobility</b> Ability to move from room to room without physical assistance			
<b>Continence</b> Ability to voluntarily control bowel & bladder functions so as to maintain personal hygiene			
<b>Dressing</b> Putting on & taking off all necessary items of clothing without assistance of another person			
<b>Bathing / Washing</b> Ability to was in the bath or shower, include getting in & out of bath or shower or wash by any other means without assistance of another person			
<b>Eating</b> All task of getting food into the body without assistance of another person			

Any other significant neurological examination findings or disability details that are not stated above :

\_\_\_\_\_

What is the prognosis of the patient's neurological impairment?  You may tick more than one.	<input type="checkbox"/> Recovered <input type="checkbox"/> Stable and Improving <input type="checkbox"/> Progressively worsening <input type="checkbox"/> No change. Likely to be permanent <input type="checkbox"/> For Multiple Sclerosis – History of multiple exacerbations and remissions. Please indicate number of exacerbations since diagnosis :
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## 5. Declaration & Authorization

I HEREBY CERTIFY that I have personally examined and treated the Patient in connection to the above condition and that the facts as given above present my opinion of his / her condition. I declare and agree to make the declaration of this claim form.

Signature and Official Stamp

Name :

Address :

Date :