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

			-							
			-							

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? ☐ YES ☐ NO

If YES, since when? DD MM YY

Date the patient **FIRST** consulted you for the ILLNESS
DD MM YY

Please state the symptom presented during the FIRST consultation

Symptoms	Date symptom FIRST presented? (dd/mm/yy)

Please describe FULL and EXACT diagnosis.
_____
_____

Date when ILLNESS was FIRST diagnosed
DD MM YY

Diagnosis was FIRST made by (Name of Doctor & Hospital)
_____
_____

Date when patient FIRST became aware of the illness
DD MM YY

Which of the following factors are present? Please provide the date of onset

Factors	YES	NO	Date of onset (dd/mm/yy)
Hypertension			
Diabetes Mellitus			
Hyperlipidemia			
Others, please specify :			

What is the source of information :
- ☐ Patient
- ☐ Referring doctor. Name of doctor & hospital / clinic : _____
- ☐ Others, please specify : _____

3. Medical Information

Please tick (√) and complete for the relevant sections :

Illness	Descriptions
☐ Alzheimer's Disease	What was the underlying cause? ☐ Alzheimer's Disease ☐ Drug related Brain Disorder ☐ Dementia ☐ Alcohol related Brain Damage ☐ Neurosis or Psychiatric Illness Is there a permanent clinical loss of ability of following? a. Remember ☐ Yes ☐ No b. Reason ☐ Yes ☐ No c. Perceive and understand ☐ Yes ☐ No Was there significant reduction in mental and social functioning? a. Deterioration or loss of intellectual capacity ☐ Yes ☐ No b. Abnormal behavior ☐ Yes ☐ No Does the patient require continuous supervision ☐ Yes ☐ No Is the disease reversible? ☐ Yes ☐ No
☐ Bacterial Meningitis / Encephalitis	What was the causative agent of the infection? ☐ Bacterial ☐ Fungus ☐ Virus ☐ Others, please specify : Was the lumbar puncture performed? If Yes, please submit the CSF investigation reports. ☐ Yes ☐ No For how long was the neurological deficit noted? Please state the duration From : ☐ Day ☐ Month ☐ Year To : ☐ Day ☐ Month ☐ Year Is the patient HIV positive? If yes, please provide the date that the patient first diagnosed HIV positive. ☐ Yes ☐ No ☐ DD ☐ MM ☐ YY Is the Encephalitis / Meningitis a result of HIV infection? ☐ Yes ☐ No
☐ Benign Brain Tumour	Is the tumour life threatening? ☐ Yes ☐ No Are there signs of increased intracranial pressure? ☐ Yes ☐ No Where was the location of the tumour? ☐ Brain ☐ Spine Has it caused damage to the brain? ☐ Yes ☐ No What is the nature of the tumour? ☐ Benign ☐ Malignant
☐ Brain Surgery	Did the patient undergo surgery of the brain? ☐ Yes ☐ No Please state type of surgery : ☐ Craniotomy ☐ Craniectomy ☐ Burr Hole ☐ Transphenoidal ☐ Endovascular Treatment ☐ Other Minimal Invasice Procedure ☐ Other procedure : Please provide details of surgery. Date of Surgery (dd/mm/yy) | Reason of the Surgery : Was there head trauma leading to the injury? ☐ Yes ☐ No If yes, please provide details : Was a Cerebral Shunt implanted during the surgery? ☐ Yes ☐ No If yes, please provide details :

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

☐ Parkinson's Disease	What was the underlying cause of the disease? ☐ Idiopathic ☐ Drug Induced, please specify : ☐ Toxins, please give details : Was there permanent clinical impairment of motor function associated with ☐ Tremor ☐ Rigidity of Movement ☐ Postural Instability Is the patient treated with medication? ☐ Yes ☐ No Was the disease well controlled by medication? ☐ Yes ☐ No
☐ Stroke	Cause of Stroke ☐ Infarct ☐ Hemorhage ☐ Embolus Patient's physical and mental status on last consultation Physical Mental
Please provide us with any other information that will enable the Company to assess this claim. _____ _____	

4. Neurological Examination Report

The following questions is based on the Patient's physical and neurological impairments based on **latest / current assessment :**

Date wen neurological impairments were first noted : ☐ DD ☐ MM ☐ YY

Date of latest / current assessment : ☐ DD ☐ MM ☐ YY

Vision (Visual Acuity)

Remarks :

	Right	Left
Normal		
Impaired		
Scored based on Metric Acuity		

Hearing (Supported by an Audiometry results)

Remarks :

	Right	Left
Normal		
Impaired		
Scored based on speech reception threshold	dB	dB

Function of speech

Remarks :

☐ Clear and understandable
☐ Slurred
☐ Unable to speak

Cognitive Function

☐ Normal ☐ Difficult with logic & reasoning
☐ Poor Comprehension ☐ Memory loss

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**
Transfer Getting in & out of a chair without physical assistance			
Mobility Ability to move from room to room without physical assistance			
Continence Ability to voluntarily control bowel & bladder functions so as to maintain personal hygiene			
Dressing Putting on & taking off all necessary items of clothing without assistance of another person			
Bathing / Washing 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			
Eating 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.	☐ Recovered ☐ Stable and Improving ☐ Progressively worsening ☐ No change. Likely to be permanent ☐ For Multiple Sclerosis – History of multiple exacerbations and remissions. Please indicate number of exacerbations since diagnosis :

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.

Name :

Address :

Date :

Signature and Official Stamp