

Claim No. (For Office Use Only)									
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# Confidential Medical Questionnaire – Organ-Specific Disorders and Dysfunction

## Instructions & Important Note:

- This form must be completed by the attending doctor (a registered Medical Practitioner, licensed and qualified to practice western medicine, and working within their scope of licensing / training) at the claimant's expense.
- The attending doctor must tick (✓) and complete all relevant part(s) below.
- If there is insufficient space, please use a separate sheet(s) of paper for your response.

## Part A : Details of Patient (Life Assured) - This section is COMPULSORY to be completed for all Critical Illnesses

1. Name		2. Gender	[ ] Male [ ] Female
3. New NRIC Number		4. Old IC No. / Passport No / Birth Certificate No.	
5. Age		6. Policy Number	

Important Note: Please enclose copies of all laboratory reports including x-rays, CT scans, other imaging studies, laboratory evidence, post-surgery report, renal biopsy, blood and laboratory test results (for SLE-blood test on antibodies), ultrasound/imaging study of kidney, haemodialysis report, etc. and any relevant hospital reports that are available.

## Part B: Details of Diagnosis - Question 1 to 7 are COMPULSORY to be completed for all Critical Illnesses

1 a Are you the patient's regular doctor?  Yes  No

b If Yes, since when? 

D	D	M	M	Y	Y	Y	Y
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2 a When were you first consulted for this illness? 

D	D	M	M	Y	Y	Y	Y
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b What were the symptoms / complaints?  
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c Date of onset of symptoms / complaints 

D	D	M	M	Y	Y	Y	Y
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**Diagnosis**

3 a Full and exact diagnosis  
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b When was the illness FIRST diagnosed? 

D	D	M	M	Y	Y	Y	Y
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c When was the patient / patient's next of kin first informed of the diagnosis? 

D	D	M	M	Y	Y	Y	Y
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d What was / were the underlying cause(s)?  
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4 a Details of investigations performed  
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b Date of investigations performed

D	D	M	M	Y	Y	Y	Y
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c Details of treatment rendered

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d Date of last consultation

D	D	M	M	Y	Y	Y	Y
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e The patient's condition as at last consultation date

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**Details of Hospitalisation**

5 a Name of hospital

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b Date and time of admission

D	D	M	M	Y	Y	Y	Y
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 \_\_\_\_ am/pm

c Date and time of discharge

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 \_\_\_\_ am/pm

d Name of surgery performed

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e Date of surgery

D	D	M	M	Y	Y	Y	Y
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f Was the patient admitted to Intensive Care Unit (ICU)?

Yes  No

If "Yes", how many days: \_\_\_\_\_

g Was the patient placed on life support measures?

Yes  No

If "Yes", how many days: \_\_\_\_\_

Which of the following essential life support was used?

- Invasive ventilator-assisted breathing through tracheal intubation
- Extracorporeal membrane oxygenation (ECMO)
- Intra-aortic balloon pump (IABP)
- Hemofiltration, haemodialysis, peritoneal dialysis or total parenteral nutrition
- Others, please specify: \_\_\_\_\_

6 Is the current diagnosis related to:

- Congenital
- Hereditary
- Due to Alcohol / Drugs
- Self-inflicted Injury
- Mental / Emotional / Sleeping Disorder
- Pregnancy / Childbirth / Miscarriage
- Acquired Immune Deficiency Syndrome (AIDS)
- Human Immuno-deficiency Virus (HIV) Infection
- Traumatic Injury
- None of the above

7 To your knowledge, has the patient suffered from any of the following illness / condition?

- a Hyperlipidemia
- b Hypertension
- c Diabetes Mellitus
- d Any Other Illness or Disability, please specify.

Yes	No	Date of Onset	Name of Doctor / Clinic / Hospital
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		

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**Part C: Details of Critical Illness - This section is applicable to SPECIFIC CRITICAL ILLNESS only**

**8 Fulminant Viral Hepatitis**

a If the liver disease is caused by viral hepatitis, what is the type of virus involved?

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b Please describe the extent of the disease.

(i) Is the size of liver rapidly decreasing?

Yes

No

(ii) Is there necrosis of entire liver lobules?

Yes

No

(iii) Is there deterioration of liver function tests?

Yes

No

(iv) Is there deepening jaundice?

Yes

No

**9 End Stage Liver Failure**

a Has the liver failure reached the end stage?

Yes

No

b Is the liver disease associated with drug or alcohol misuse?

Yes

No

c Please describe the extent of the disease.

(i) Is there permanent jaundice?

Yes

No

(ii) Is there ascites?

Yes

No

(iii) Is there hepatic encephalopathy?

Yes

No

(iv) Is there portal hypertension?

Yes

No

d Is the encephalopathy a form of Wernicke's encephalopathy?

Yes

No

**10 End Stage Lung Disease**

a Has the lung disease reached end stage?

Yes

No

b What is the underlying cause leading to respiratory failure?

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c Does the patient have dyspnea at rest?

Yes

No

d Is the patient on continuous permanent oxygen therapy at present?

Yes

No

e Is there a permanent impairment of lung function with a consistent Forced Expiratory Volume (FEV) of less than one (1) liter during the first second?

Yes

No

f What is the lung function test result?

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g What is the baseline arterial blood gas analysis result?

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11

**Major Organ / Bone Marrow Transplant**

a Please provide full and exact details of the diagnosis leading to transplant surgery.

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b Which of the following organ is involved?

- Kidney
- Lung(s)
- Liver
- Heart
- Pancreas
- Small Bowel
- Bone Marrow
- Other organ, please specify: \_\_\_\_\_

c What is the condition/illness leading to the necessity of organ transplant?

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d For human bone marrow, is it using hematopoietic stem cells?

Yes  No

e Has the patient undergone the transplant surgery as a recipient?

Yes  No

If "Yes", please give details of transplant surgery performed.

Date of Surgery	Type of Transplant	Doctor and Hospital Name

If "No", please state if the patient is on an official Malaysia waiting list as a recipient for a transplant? Please submit the official confirmation document:

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12

**Systemic Lupus Erythematosus (SLE) with Severe Kidney Complications**

a If the kidney disease is due to Systemic Lupus Erythematosus (SLE), please indicate the WHO classification of the Type of Lupus Nephritis as confirmed by renal biopsy.

- Type I - Minimal change glomerulonephritis
- Type II - Mesangial glomerulonephritis
- Type III - Focal Segmental glomerulonephritis
- Type IV - Diffuse glomerulonephritis
- Type V - Membranous glomerulonephritis

b Which of the following areas or organs are involved in SLE?

- Blood
- Skin
- Joints
- Lungs
- Kidneys
- Other organ, please specify: \_\_\_\_\_

c Does the patient have discoid lupus?

Yes

No

d Please select the clinical manifestations exhibited by the patient.

Malar rash

Photosensitivity

Oral ulcers

Arthritis

Serositis

Renal disorder

Blood disorder, i.e. Leukopenia / Lymphopenia / Haemolytic anaemia / Thrombocytopenia

Positive Anti-nuclear antibodies

Positive L.E. cells

Positive Anti-DNA

Positive Anti-Sm (Smith IgG Auto-antibodies)

Others, please specify: \_\_\_\_\_

e What is the stage of renal failure?

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f Please provide the details below and enclose copies of the biopsy report and investigation reports.

(i) Date of Biopsy

D	D	M	M	Y	Y	Y	Y
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(ii) Biopsy/Investigation Result

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Note: Please enclose copies of all investigation performed, e.g. renal biopsy results, blood and laboratory test results (for SLE-blood test on antibodies), ultrasound / imaging study of kidney, haemodialysis card, renal function test with electrolytes report, etc.

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13

**Third Degree Burns**

a What were the causes of the burns?

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b Were the burns caused by accident?

Yes

No

If "Yes", please give details:

(i) Date of Accident occurred

D	D	M	M	Y	Y	Y	Y
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(ii) Where did it occur?

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(iii) How did it occur?

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c Were the burns self-inflicted?

Yes

No

If "Yes", please give details:

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d What is the percentage of total body surface area burnt?

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e What was the degree of burns?

- 1<sup>st</sup> degree
- 2<sup>nd</sup> degree
- 3<sup>rd</sup> degree

f If there were 3<sup>rd</sup> degree burns, what percentage of total body surface area had 3<sup>rd</sup> degree burns?

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g How long was the patient in hospital?

\_\_\_\_\_ days

h Was any skin graft done?

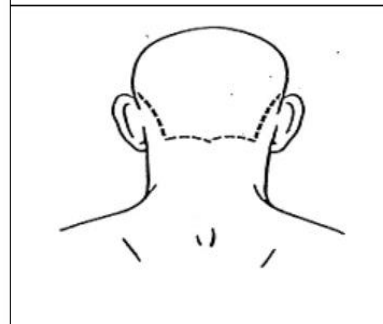
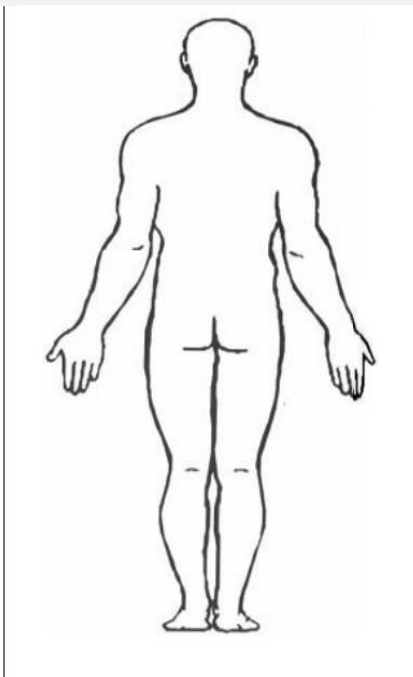
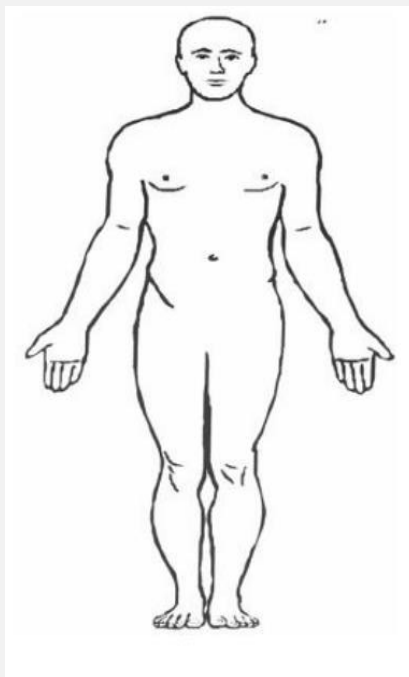
- Yes
- No

If "No", please give reason:

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i Please indicate on the Total Body Surface Area Burns Assessment figure below the areas that were burnt or attach a copy of the report from the medical record.

Please illustrate all the burnt areas and specify the areas with 3<sup>rd</sup> degree burns in the following diagrams.



14

**Blindness**

a What is the best corrected visual acuity of both eyes at present?

(i) Date of test performed

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

(ii) Name of test performed

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(iii) Right eye

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(iv) Left eye

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b Please tick the relevant box for the severity of patient's visual acuity of both eyes at present.

(i) Right eye

- Normal
- Severe but not totally loss of sight
- Total and irrecoverable loss of sight
- None of the above, please specify: \_\_\_\_\_

(ii) Left eye

- Normal
- Severe but not totally loss of sight
- Total and irrecoverable loss of sight
- None of the above, please specify: \_\_\_\_\_

c Please confirm whether the patient is suffering from any of the following.

- Loss of sight – without perception of light
- Loss of sight – with perception of light
- None of the above, please specify: \_\_\_\_\_

d What are the underlying causes?

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e What forms of treatment were rendered?

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f What is the prognosis?

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g Will further surgery or other therapy improve patient's sight?

- Yes       No

If "Yes", please give details (type of surgery, therapy, date, etc) of completed, current or planned treatment.

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h Is the loss of sight total and irreversible?

- Yes       No

15

**Deafness**

a Was the diagnosis confirmed by an audiometric and sound-threshold test?

- Yes       No

b What are the underlying causes?

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c What is the prognosis?

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d Is the loss of hearing total and irreversible?

- Yes       No

e What is the degree of hearing loss in all frequency of hearing using a pure tone audiogram or sound-threshold tests in both ears?

Right ear : \_\_\_\_\_ dB

Left ear : \_\_\_\_\_ dB

f Can it be reversible by hearing aid / surgical / other devices?

- Yes       No

g If a hearing aid was not recommended, please give details as to why it was not recommended.

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h Has the patient previously suffered from any ear disease, exposure to noisy environment or any significant illness?

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**Loss of Speech**

a How long is the duration of the loss of speech?

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b Is the loss of speech considered total and irreversible?

Yes  No

c What are the underlying causes?

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d Is the loss of speech caused by injury or illness to the vocal cords?

Yes  No

If "Yes", please elaborate on the type of injury or illness and how does it result in loss of speech?

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e What is the prognosis?

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f Does the patient have any psychiatric disorders?

Yes  No

g Is the loss of speech related to the psychiatric disorder?

Yes  No

If "Yes", please give details:

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h Will further surgery or other therapy improve patient's loss of speech?

Yes  No

If "Yes", please give details (type of surgery, therapy, date, etc) of completed, current or planned treatment.

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Part D: Patient's Medical Information - This section is <b>COMPULSORY</b> to be completed for all Critical Illnesses												
1. Please provide the name and address of all doctors, specialists, or hospitals to which the patient has been referred or attended for this condition.												
Consultation Date(s)	Name of Doctor	Name and Address of Clinic / Hospital										
2. (a) Has the patient <u>previously</u> suffered from this disease or any related illness?				<input type="checkbox"/> Yes <input type="checkbox"/> No								
(b) If Yes, please state the dates of consultations, diagnosis, name of doctor, name of clinic / hospital and the treatments / medications given.												
Consultation Date(s)	Diagnosis	Name of Doctor	Name of Clinic / Hospital	Treatment / Medication(s) Given								
3. In your opinion, is there any further information that will assist us in assessing the claim. If Yes, please furnish such information below.												
I hereby certify that I have personally examined and treated the patient for the above injuries / illness. I hereby declare that all the answers and statements are complete and true to the best of my knowledge, belief and that I have withheld no material fact from the Company. I also hereby certify that the above information is correct as per records from the hospital / clinic.												
Signature of Attending Physician		Name & Qualification of Attending Physician		Official Stamp of Hospital								
Date		Email Address		Telephone No								
<table border="1" style="width:100%; text-align: center;"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>		D	D	M	M	Y	Y	Y	Y			
D	D	M	M	Y	Y	Y	Y					

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