

**CONFIDENTIAL MEDICAL CERTIFICATE
(CRITICAL ILLNESS - BRAIN, NERVE & MUSCLE RELATED CONDITION)**



Certificate No. <input type="text"/>	New NRIC No. <input type="text"/> - <input type="text"/> - <input type="text"/>
Certificate No. <input type="text"/>	Old NRIC/Birth Certificate/ Passport No. <input type="text"/>
Certificate No. <input type="text"/>	Name of Person Covered _____
Certificate No. <input type="text"/>	

The above name is covered with GREAT EASTERN TAKAFUL BERHAD against the happening of certain contingent events associated with his / her health. A claim has been submitted within the coverage of a Critical Illness benefit and to enable us to assess the claim, kindly complete this confidential report.
(For any medical report fee incurred in completing this form, it will be borne by claimant)

Please attach certified true copies of ALL the relevant laboratory evidences / tests available.

- | | |
|--|---|
| <input type="checkbox"/> CT Scan / MRI report of the Brain | <input type="checkbox"/> Blood test reports |
| <input type="checkbox"/> MRI of Spine | <input type="checkbox"/> Surgery report |
| <input type="checkbox"/> Lumbar puncture test report | <input type="checkbox"/> Histopathology examination (HPE) |
| <input type="checkbox"/> Electromyography (EMG) test results | <input type="checkbox"/> Biopsy report |
| <input type="checkbox"/> Nerve conduction study/ Evoked potential test | |
| <input type="checkbox"/> Other reports. Please give details: _____ | |

1. Are you the Person Covered's usual medical attendant? Yes No
If "YES", since what date? / / (dd/mm/yyyy)

2. Has the Person Covered previously suffered from or detected to have hypertension, diabetes, angina, hyperlipidaemia, cardiovascular disease, transient ischaemic attack, neurological disorders, renal disease, hepatitis B or C, autoimmune disorder or any other significant illnesses?
 Yes No
If "YES", please provide the following:

Medical Condition	Date of Diagnosis	Medication / Treatment	Name of Treating Doctor	Name and Address of Clinic / Hospital

3. Date when Person Covered FIRST consulted you for the illness. / / (dd/mm/yyyy)

4. Please state the symptoms presented during the date of FIRST consultation, as stated in Question 3, and for how long the Person Covered had been experiencing these symptoms.

Symptoms	Date symptoms first presented (dd/mm/yyyy)
(a)	
(b)	

What is the source of this information?
 Person Covered
 Referring doctor
 Name of doctor and hospital / clinic: _____
 Others, please specify: _____

5. Diagnosis

(i) Please describe the full and exact diagnosis.	(i) _____
(ii) Date when the illness was FIRST diagnosed	(ii) <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)
(iii) Diagnosis was FIRST made by (name of doctor and hospital)	(iii) _____
(iv) Date when Person Covered FIRST became aware of the illness.	(iv) <input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)

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Great Eastern Takaful Berhad (916257-H)

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6. What is the underlying cause of the illness as per diagnosis above?	_____
7. Type of investigations / tests done to confirm the diagnosis.	_____
8. Please give details of completed, planned or current treatment for the illness stated above.	_____
9. Is the Critical Illness associated with any other disorder, for example neurosis, psychiatric illness, HIV infection, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", please give details. _____
10. The condition was associated with: (Please elaborate in details)	<input type="checkbox"/> self-inflicted injury <input type="checkbox"/> drug or alcohol misuse <input type="checkbox"/> Others: _____

11. Please tick and complete for the relevant sections:

<input checked="" type="checkbox"/> Please tick	Items	Descriptions
<input type="checkbox"/> Stroke	Cause of stroke:	<input type="checkbox"/> Infarct <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Embolus
<input type="checkbox"/> Parkinson's Disease	(i) Cause of Parkinson's Disease: (ii) Can the condition / illness be controlled with medication?	(i) <input type="checkbox"/> Idiopathic <input type="checkbox"/> Secondary due to: _____ (ii) <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Motor Neuron Disease	Type of Motor Neuron Disease:	<input type="checkbox"/> Amyotrophic lateral sclerosis <input type="checkbox"/> Progressive bulbar palsy <input type="checkbox"/> Primary lateral sclerosis <input type="checkbox"/> Spinal muscular atrophy
<input type="checkbox"/> Muscular Dystrophy	Type of Muscular Dystrophy:	<input type="checkbox"/> Duchenne's <input type="checkbox"/> Myotonic <input type="checkbox"/> Facioscapulohumeral <input type="checkbox"/> Congenital <input type="checkbox"/> Others: _____
<input type="checkbox"/> Alzheimer's Disease	Type of conditions involved:	<input type="checkbox"/> Alzheimer's disease <input type="checkbox"/> Dementia <input type="checkbox"/> Other degenerative brain disorders
<input type="checkbox"/> Major Head Trauma	What is the exact location and extent of the head injury?	_____
<input type="checkbox"/> Coma	(i) How long was the Person Covered in a state of coma, with no response to external stimuli? (ii) Was the coma 'Medically induced'? (iii) How long was the Person Covered on a ventilator?	(i) _____ hours / _____ days since <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy) _____ am/pm (ii) <input type="checkbox"/> Yes <input type="checkbox"/> No (iii) _____ hours / _____ days First on ventilation since : <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy)
<input type="checkbox"/> Benign Brain Tumour	(i) Is the tumour life threatening? (ii) Are there signs of increased intracranial pressure? (iii) Has it caused damage to the brain?	(i) <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", please give details. _____ (ii) <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", please give details. _____ (iii) <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", please give details. _____

<input checked="" type="checkbox"/> Please tick	Items	Descriptions
<input type="checkbox"/> Bacterial Meningitis / Encephalitis	Please provide Cerebrospinal Fluid (CSF) test results	_____ _____ _____ _____
<input type="checkbox"/> Brain Surgery	(i) Please state type of surgery: (ii) Reason for surgery: (iii) Was the surgery done due to injuries sustained during an accident? (iv) Please state date of surgery:	(i) <input type="checkbox"/> Craniotomy <input type="checkbox"/> Craniectomy <input type="checkbox"/> Other procedure : _____ (ii) _____ (iii) <input type="checkbox"/> Yes <input type="checkbox"/> No (iv) <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy)

12. Please provide us with any other information that will enable the Takaful Operator to assess this claim.

13. **Neurological Examination report:**

Please state below (**Question a - h**), the Person Covered's physical and neurological impairments, **based on latest / current assessment:**

Date when neurological impairments were first noted: / / (dd/mm/yyyy)

Date of latest/current assessment: / / (dd/mm/yyyy)

(a) Vision (Visual Acuity)	<table border="1"> <thead> <tr> <th></th> <th>Right</th> <th>Left</th> </tr> </thead> <tbody> <tr> <td>Normal</td> <td></td> <td></td> </tr> <tr> <td>Impaired</td> <td></td> <td></td> </tr> <tr> <td>Scores based on Metric Acuity</td> <td></td> <td></td> </tr> </tbody> </table> <p>Remarks: _____</p>		Right	Left	Normal			Impaired			Scores based on Metric Acuity		
	Right	Left											
Normal													
Impaired													
Scores based on Metric Acuity													
(b) Hearing (Supported by an Audiometry results)	<table border="1"> <thead> <tr> <th></th> <th>Right</th> <th>Left</th> </tr> </thead> <tbody> <tr> <td>Normal</td> <td></td> <td></td> </tr> <tr> <td>Impaired</td> <td></td> <td></td> </tr> <tr> <td>Scores based on speech reception threshold</td> <td>dB</td> <td>dB</td> </tr> </tbody> </table> <p>Remarks: _____</p>		Right	Left	Normal			Impaired			Scores based on speech reception threshold	dB	dB
	Right	Left											
Normal													
Impaired													
Scores based on speech reception threshold	dB	dB											
(c) Function of speech	<input type="checkbox"/> Clear and understandable <input type="checkbox"/> Slurred <input type="checkbox"/> Unable to speak <p>Remarks: _____</p>												
(d) Cognitive function	<input type="checkbox"/> Normal <input type="checkbox"/> Poor comprehension <input type="checkbox"/> Difficult with logic and reasoning <input type="checkbox"/> Memory loss <p>Remarks: _____</p>												

<p>(e) General examination findings:</p> <p>(i) Are there any abnormal movements or abnormal gait? (Please provide full details)</p> <p>(ii) Is there any muscle wasting? (Please provide full details)</p> <p>(iii) If there are any other significant examination findings, please provide the details.</p>	<p>(i) _____</p> <p>_____</p> <p>_____</p> <p>(ii) _____</p> <p>_____</p> <p>_____</p> <p>(iii) _____</p> <p>_____</p> <p>_____</p>
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(f) Examination of the Limbs
Please indicate the **muscle power** of the various joint in the table below with the maximum grade of 5.

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

(g) Assessment of Activities of 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)			
Continenence (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 wash in the bath or shower, including 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)			

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

14. What is the prognosis of the Person Covered's neurological impairments?
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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DECLARATION: TO BE COMPLETED BY THE ATTENDING PHYSICIAN / SPECIALIST

I, the undersigned, certify that I have examined the above Person Covered and that I have answered the above questions are true and to the best of my knowledge and belief.

<div style="border: 1px solid black; height: 100px; width: 100%;"></div> <p>Signature and Official Stamp</p>	<p>Name: _____</p> <p>Address: _____</p> <p>Date: <input type="text" value=""/> / <input type="text" value=""/> / <input type="text" value=""/> (dd/mm/yyyy)</p>
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