

### STATEMENT OF MEDICAL EXAMINER – DEATH CLAIM

#### SECTION B

- Section B of this form is to be completed by a legally qualified and registered medical practitioner who has treated the Deceased for the injuries s/ illness sustain.
- Expenses incurred to obtain this report will be borne by the Claimant / Next of Kin.

Certificate no: .....

Name of deceased in full: .....

NRIC no. : ..... Sex: ☐ Male ☐ Female Age: .....

Date of Birth: ..... Occupation at time: .....

1. Date and Time of Death: ..... 2. Place of Death: .....

3. Cause of Death: .....

4. Are you the patient's regular doctor? ☐ Yes ☐ No

5. Since when have you known the deceased? .....

6. i) Date the patient first consulted you (dd/mm/yyyy) : .....

ii) What was the diagnosis at the first consultation: .....

iii) According to the deceased, how long do you feel the deceased had the symptom: .....

iv) In your opinion, how long do you feel the deceased has the symptom; .....

7. i) Were you consulted by the deceased during his/her last illness? ☐ Yes ☐ No

ii) If not, please give the name and address of the attending doctor: .....

8. If deceased was hospitalized, please state:

Admission Date: ..... Discharge Date: ..... Diagnosis: ..... Place: .....

.....

.....

.....

.....

.....

.....

.....

.....

9. a) What was the immediate cause of death? Provide condition, injury or complication which directly leads to death:

.....

b) When, where and by whom was the illness first diagnosed? Date: ..... Place: ..... By Whom: .....

c) Was Deceased/ family informed of the diagnosis? ☐ Yes ☐ No

10. a) If the primary cause of death differs from the immediate cause, please state the primary cause.....

.....

b) When and where it was first diagnosed? Date: ..... Place: .....

c) Was Deceased / family informed of the diagnosis? ☐ Yes ☐ No

d) Was the Deceased referred to you by other doctor? ☐ Yes ☐ No

Please state reason: ..... Please give name and address of the doctor: .....

11. Give details of any follow-up(s), or referral by / to other doctor(s), if any

Name & Address of Doctors / Hospital

Date of Attendance

Illness or condition consulted

.....

.....

.....

.....

.....

.....

.....

.....

.....

12. Was death due to ☐ self-inflicted ☐ homicide ☐ accident ☐ suicide

Please give details .....

.....

13. If death due to accident, please give details:

i. Date of accident: ..... (dd/mm/yyyy) Time.....(am/pm)

ii. How did the accident happen? .....

CERTIFICATE NO:

iii. Was the deceased suspected to be under the influence of any alcohol or drug? ☐ Yes ☐ No

If yes, was there any sample of urine or blood sent for further test? ☐ Yes ☐ No

iv. In your opinion / investigation, do you think that the death resulted from the accident? ☐ Yes ☐ No

14 Was there any predisposing cause directly or indirectly to Deceased death?

i. Habit use of tobacco, alcohol, narcotics ☐ Yes ☐ No

ii. Family History ☐ Yes ☐ No

iii. Occupation of Deceased ☐ Yes ☐ Noiv. HIV / AIDS ☐ Yes ☐ No

If 13 (iv) is yes, was the illness transmitted via blood transfusion? ☐ Yes ☐ No

15. Please state below from past records or from your personal knowledge details of all illnesses, accidents, treatments and/or surgical procedures performed for the diseases that deceased had suffered from in this hospital or any other hospitals.

<u>Date of Onset / Diagnosed</u>	<u>Symptoms</u>	<u>Disease / Diagnosis</u>	<u>Treatment / Management</u>	<u>Name of Hospital / Clinics</u>

16. Was an inquest or post-mortem examination held on the body? ☐ Yes ☐ No

If yes, please furnish certified copy of verdict or findings

If so, state which, by whom and the results .....

17. If the Deceased 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)	Result for Blood Glucose (fasting)
-------------------	----------------------------	-------------------	------------------------------------

i. ....

ii. ....

iii. ....

18. Details of other attending doctors who had treated the Deceased in the last **two** years

19. Any further information which in your opinion will assist us in assessing the claim? .....

**20. To attach photocopy of detailed medical history/ medical card of the Deceased.**

CERTIFICATE NO:

**DECLARATION**

I, the attending physician do solemnly and sincerely declare that the foregoing answer and any additional information given by me at the bottom of this 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 : .....

Name and Address of Clinic / Hospital: .....

.....

Official Stamp of Doctor:

Hospital / Clinic Official Stamp

.....

.....