Family Takaful

STATEMENT OF MEDICAL EXAMINER – TOTAL & PERMANENT DISABILITY CLAIM

SECTION B

1. Section B of this form is to be completed by a legally qualified and registered medical practitioner who has treated the Person Covered for the injuries / illness sustained.
2. This form should be completed by the latest attending doctor after a minimum of six (6) months from the disability commencement date.
3. Expenses incurred to obtain this report will be borne by the Person Covered.
4. No claim shall be accepted unless this report is duly completed and signed by the said medical practitioner.
5. Please use extra page where space provided is not sufficient for your reporting.

Contract No : ……

Name of Patient in Full : ……

NRIC No. : ……. Age: ……

Occupation : ……..

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

2. How long have you been his Medical Physician. ……

3. a) Date of first consultation ..... (dd/mm/yy)
   b) Reason for consultation : …….

   c) Date of first consultation for his/her current disability .....(dd/mm/yy)

   d) Was the patient referred to you by other doctor : ☐ Yes ☐ No
   If yes,

   i) Please give name and address of the doctor: ……
   ……

   ii) Date referred ..... (dd/mm/yy)
   Reason: ……..
   ……
   ……

e) What were the presenting symptoms when you first saw the patient: ……

   i) When did the above symptoms first presented ..... (dd/mm/yy)
   ii) If the date is unknown, please state how long the symptoms had been presented prior to the date of first consultation, their frequency and severity .
   ……
   ……..

f) Please provide the full exact details and the diagnosis :
   Date diagnosed : Diagnosis :

…… (dd/mm/yy) ……
…… (dd/mm/yy) ……
…… (dd/mm/yy) ……
…… (dd/mm/yy) ……

g) Date the patient was informed of the diagnosis..... (dd/mm/yy)

   i) What was the exact information conveyed to the patient: ……..
   ……..
   ……..

h) Please provide details of treatment that has been provided to the patient, including any operation and the date(s) performed :

Date	Type of treatment/surgery/procedure	Diagnosis

i) Is this disability related to any other condition from which the patient has suffered in the past? ☐ Yes ☐ No
If yes, please specify:

Date of diagnosis	Diagnosis/Condition	Name of the doctor who diagnosed	Name of hospital/clinic

j) Did the patient consult other doctors for other illnesse(s) BEFORE he/she consulted you? ☐ Yes ☐ No
If yes, please give name(s) and address(es) of the doctor(s) whom he/she consulted

Name of doctor	Name of hospital/clinic	Date of consultation	Diagnosis

4. a) Is the condition a result of an accident ? ☐ Yes ☐ No
If yes, please state the date of accident: …….. (dd/mm/yyyy) Time of accident..... (am/pm)
Describe in detail how the accident happened :
……
……

b) Was the patient under the influence of alcohol/drugs at time of accident : ☐ Yes ☐ No
If yes, please state the blood alcohol content/drug type and quantity consumed :
……
……

c) Is the condition self-inflicted? ☐ Yes ☐ No
If yes, please provide full details: ……..
……..

d) Is the patient suffering from any loss of limbs or/and fingers? ☐Yes ☐ No
If yes,
i) Please state the power of patient's upper and lower limbs

Right upper limb: …… Right lower limb: ……

Left upper : …… Left lower limb: ……

ii) When did such disability commence ..... (dd/mm/yyyy)

e) Did the patient suffer amputation of limbs or/and fingers? ☐ Yes ☐ No
If yes,
i) Please state level of amputation seen (proximal/middle/distal): ……..
ii) When did such disability commence .....(dd/mm/yyyy)

f) Is the patient suffering from total and irrecoverable loss of right eye and the left eye?
Right Eye : ☐ Yes ☐ No
Left Eye : ☐ Yes ☐ No
If yes,
i) please give details on patient's visual acuity: i) Right eye ……. ii) Left eye …….
ii) When did such disability commence ..... (dd/mm/yyyy)

g) Did the patient suffer loss of hearing for both ears? ☐ Yes ☐ No
If yes,
i) please give details on patient's hearing: i) Right ear ……. ii) Left ear …….
ii) When did such disability commence;.....(dd/mm/yyyy)

5 a) Date of last consultation .....(dd/mm/yyyy)

i) Condition as at last date of consultation :
☐ Recovered? If so, please give date :
☐ Improved?
☐ Not changed?
☐ Deteriorated?

ii) Please describe in details: …….
b) Is the patient currently :
☐ Ambulatory ☐ Confined at home ☐ Confined at hospital ☐ Confined at bed
☐ Subject to some other restriction in movement or lifestyle? If so, please give details: ……

c) Is the Person Covered able to perform all the 6 Activities of Daily Living (ADL) without assistance)

Activities of Daily Living	Participant able to perform	
Transfer	Yes	No
Mobility	Yes	No
Continence	Yes	No
Dressing	Yes	No
Bathing / Washing	Yes	No
Eating	Yes	No

d) How would you assess the patient's degree of limitation in performing the following activities :

	Not Limited	Mildly Limited	Moderately	Severely Limited	Incapable
Lifting & Carrying	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐
Changing Posture	☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐	☐
Dexterity	☐	☐	☐	☐	☐
Working with both hands	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐	☐
Crawling	☐	☐	☐	☐	☐
Squatting	☐	☐	☐	☐	☐
Walking on uneven surface	☐	☐	☐	☐	☐
Reach above shoulder	☐	☐	☐	☐	☐

Patient can used hand for repetitive action

	Right Hand		Left Hand	
Simple Grasping	☐ Yes	☐ No	☐ Yes	☐ No
Fine manipulating	☐ Yes	☐ No	☐ Yes	☐ No
Forearm rotation movement	☐ Yes	☐ No	☐ Yes	☐ No
Power grip	☐ Yes	☐ No	☐ Yes	☐ No
Pushing / Pulling	☐ Yes	☐ No	☐ Yes	☐ No

6. a) Please describe the nature and severity of the patient's disability in respect of this illness/injury.

……..

b) Is the disability progressing/stagnant/recovering :

……..

c) Considering the patient current health condition, what would you rate his/her present physical capacity?

☐ Following his / her normal occupation on a full time basis?
☐ Following his / her normal occupation on a part-time basis?
☐ Following a different occupation?
Please provide details for any of the answer above, if any ……...

d) Is the patient able to perform all the normal duties of his/her usual occupation ? ☐ Yes ☐ No
If yes, when is he/she expected to return to his usual occupation .....(dd/mm/yy)

e) If the patient is unable to return to his/her usual occupation, is he/she able to engage in any other occupation?
☐ Yes ☐ No

If yes, what type of occupation can he/she be engaged in: ……
……

f) When do you think the patient will be able to resume working, either to his/her present job or alternative employment /

……

g) To what extent does the disability prevent him from performing all the normal duties of his usual occupation?

……

h) Is full recovery expected? ☐ Yes ☐ No
i) If yes, please state approximate date..... (dd/mm/yy)
ii) If no, please state the extent of recovery and approximate date of the stated extent of recovery :

……

i) Please give full details with respect to the patient's mental abilities and cognition :

……

7. To your knowledge, has the patient been fully compliant with the treatment suggested? Are there any other circumstances, medical or otherwise, which may delay the patient's recovery ?

……

……

8. Is there any other functional impairment present? .....

……

9. i) Is the patient physically incapacitated from ever continuing in any employment ? ☐ Yes ☐ No
ii) Is the patient mentally incapacitated from ever continuing in any employment? ☐ Yes ☐ No

If yes, when did such disability commence..... (dd/mm/yy)

10. Do you consider the patient's condition to be totally disabled? ☐ Yes ☐ No
If yes, when did such disability commence?..... (dd/mm/yy)

11. If the incapacity of the patient cannot be confirmed upon last consultation/examination date, would you recommend a review of his/her condition in the near future ? ☐ Yes ☐ No

If yes, what is the appropriate time period for you to reassess his/her condition.....(dd/mm/yy)

12. In your opinion, what would be the percentage (%) of loss of income due to the disability? ……

13. Please provide us with any other additional information that will enable the Company to assess this claim. Kindly enclose copies of the medical test results, if any.

……
……
……

DECLARATION:
I,.....the undersigned, do hereby declare the foregoing answers are true to the best of my knowledge and belief and that no material fact has been concealed from the Company. Furthermore, I certify that I have personally examined the identity of the above-named Participant and the facts as stated above represent my medical opinion of his/her condition.

……	……
Signature of the Attending Physician	Date (dd/mm/yyyy)
……	……
Name of the Attending Physician	Contact No.
……..	……
Professional Qualification	Official Stamp and Address