HongLeong Assurance

C012613030

Policy No.: _____ Claim No.: _____

MEDICAL ATTENDANT'S REPORT

(Facial Reconstructive Surgery / Pregnancy Complications)

This report is to be completed by a registered medical practitioner at the own expense of claimant.

1. a) Name of Patient.	
b) I/C No.	
c) Date of Birth.	Date: (dd/mm/yyyy)
d) Present Occupation. (If more than one, please state all)	
2. a) Please describe the exact details of your patient's present condition.	
b) Date last seen by you.	Date: (dd/mm/yyyy)
3. a) When did your patient first consult you for the condition?	Date: (dd/mm/yyyy)
b) Symptoms presented at first consultation.	
c) Date of symptoms first appeared prior to first consultation.	Date: (dd/mm/yyyy)
4. a) Please give full details of the diagnosis.	
b) Date of diagnosis.	Date: (dd/mm/yyyy)
c) Name and address of doctor who established the diagnosis.	
d) Was your patient informed of the diagnosis? If yes, when and by whom?	Yes ☐ Doctor's name : Date : (dd/mm/yyyy) No ☐
e) How did you confirm the diagnosis? Kindly enclose a copy of report.	
5. Had your patient suffered any previous episodes of the condition or any other conditions leading to it or relating to it? If yes, please give details.	Yes ☐ Details: No ☐
6. a) Was your patient referred to you? If yes, please give name and address of doctor concerned.	
b) Name and address of doctor(s) who attended to your patient prior seeing you.	
c) Name and address of doctor(s) concurrently treating your patient with you for the condition.	
d) Was your patient referred to any other doctor(s) by yourself? Please give name and address of the doctor(s).	

7. If the condition was due to an accident, please state: a) Date and time of accident. b) Full circumstances of accident.	a) Date: (dd/mm/yyyy) Time: (am/pm) b)
8. Please answer the questions below in respect of the patient's condition.	
a) Facial Reconstructive Surgery	
i. Please provide details of any facial / neck disfigurement sustained by the patient.	
ii. Had the patient undergone any plastic or reconstructive surgery? If yes, please provide details including dates and the cost.	Yes ☐ Details: No ☐
iii. Was the surgery meant for cosmetic or reconstructive purpose?	Yes ☐ No ☐
iv. Were there any further procedures or surgery planned?	Yes ☐ No ☐
b) Disseminated Intravascular Coagulation (DIC)	
i. Was there any entrance of uterine material with tissue factor activity into the maternal circulation?	Yes ☐ No ☐
ii. Had this resulted in major haemorrhage?	Yes ☐ No ☐
iii.Please give details of treatment provided.	
c) Still Birth	
i. Particulars of pregnancy: a) Date of conception / last menstrual period. b) Duration of pregnancy. c) Estimated date of delivery.	a) Date: (dd/mm/yyyy) b) c) Date: (dd/mm/yyyy)
ii. Particulars of death of foetus: a) Date of death. b) Cause of death.	a) Date: (dd/mm/yyyy) b)
iii. Please give details whether there was elective termination of pregnancy.	
d) Ectopic Pregnancy Termination	
i. Did implantation of a fertilized ovum occur outside the uterine cavity?	Yes ☐ No ☐
ii. Please provide details of how the ectopic pregnancy was confirmed.	
iii. Was the pregnancy terminated by laparotomy or laparoscopic surgery?	Yes ☐ No ☐

e) Abruptio Placentae	
i. Was there a separation of the placenta from the uterine wall before delivery?	Yes ☐ No ☐
ii. What were the investigations done to confirm the diagnosis? Please provide the results of the investigations.	
iii. Details of the treatment provided.	
iv. Did your patient undergo an emergency caesarean section?	Yes ☐ No ☐
v. Date of death of the foetus if there is.	Yes ☐ Date of death: (dd/mm/yyyy) No ☐
f) Amniotic Fluid Embolism	
i. Was there any entrance of amniotic fluid into the mother's blood stream that cause blockage in a pulmonary artery?	Yes ☐ No ☐
ii. If yes, did it cause respiratory or cardiac arrest?	Yes ☐ No ☐
g) Eclampsia	
i. Was there an occurrence of seizures with or without coma during pregnancy, delivery or shortly after? If yes, any associated with any other brain abnormality?	Yes ☐ Details: No ☐
ii. Was it preceded by pre-eclampsia, gestational hypertension or proteinuria? If yes, please provide details of severity.	Yes ☐ Details: No ☐
iii. Had this resulted in any major complications? Please specify if any.	Yes ☐ Details: No ☐

9. Had the patient been treated for any of the following illnesses? If yes, please provide additional information as per the table below.

	Date of Diagnosis/ Onset (dd/mm/yyyy)	Name & address of Doctor(s) consulted	Dates of Consultation (dd/mm/yyyy)
a) Hypertension			
b) Diabetes Mellitus			
c) Cardiovascular Disease			
d) Other Illnesses / Injuries Please specify: i. ii.	 i. ii.	 i. ii.	 i. ii.

10. Please give other information which you feel would be helpful in the assessment of your patient's claim.	

Signature: _____

Name (in block capitals please): _____

Qualification: _____

Contact No.: _____

Date: _____(dd/mm/yyyy)

Official Stamp: