HongLeong Assurance

C014817050

Policy No. : _____ Claim No. : _____

MEDICAL ATTENDANT'S REPORT ON OUTPATIENT CANCER TREATMENT CLAIM

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. (dd/mm/yyyy)	
d) Present Occupation. (If more than one, please state all)	
2. a) Final diagnosis.	
b) What was the stage of the tumour? i. TNM classification ii. AJCC (American Joint Committee on Cancer) staging.	 i. ii.
c) Date first diagnosed. (dd/mm/yyyy)	
d) Name of doctor who established the diagnosis.	

3. Is the cancer:

☐ Newly diagnosed.

☐ A relapse. Please provide the date of relapse: _____ (dd/mm/yyyy)

4. Date of first onset of:

a) Chemotherapy. _____ (dd/mm/yyyy)

b) Radiotherapy. _____ (dd/mm/yyyy)

c) Targeted therapy. _____ (dd/mm/yyyy)

d) Hormone therapy. _____ (dd/mm/yyyy)

5. Details of treatments.

Type of Treatments	Cycles / Fractions	Interval between cycles/ fractions (day/week/month)	Expected completion date (dd/mm/yyyy)
Chemotherapy			
Radiotherapy			
Targeted therapy			
Hormone therapy			

6. All medicines used/ will be used and prescribed during and after chemotherapy/ radiotherapy/ targeted therapy/ hormone therapy.

No.	Name of medicine	Quantity per day	Duration

7. All the medicines that the patient is required/ may be required to take during the chemotherapy/ radiotherapy/ targeted therapy/ hormone therapy and indicate the purpose of the medicines.

Type of medications prescribed/will be prescribed	Purpose of the medications

8. All the tests required during the chemotherapy/ radiotherapy/ targeted therapy/ hormone therapy and indicate the purpose and reason of the tests.

Type of examinations (laboratory test, blood test, ultrasound, etc)	Purpose/ reason of the tests

9. Upon completion of the chemotherapy/ radiotherapy/ targeted therapy/ hormone therapy treatment, any further treatment that is required?	Yes ☐	No ☐

If yes, please provide the type of treatment, purpose of the treatment and for how long the treatment is required.

Type of treatments	Purpose of the treatments	Duration of treatments

10. Please provide any further information which may be of assistance to us in assessing the claim.	

Signature: _____

Name (in block capitals please): _____

Qualification: _____

Contact No.: _____

Date: _____(dd/mm/yyyy)

Official Stamp: