Section IV - Attending Physician Statement (Brain Related Claims)

(Applicable to Multiple Sclerosis, Alzheimer's Disease/Severe Dementia, Motor Neuron Disease, Stroke, Bacterial Meningitis / Encephalitis, Major Head Trauma and Brain Surgery)

Claim No: _____ Policy No: _____

The completion of this form is at the expense of the patient.

Section 1 :Patient's Information

Name:	IC No:
Date of Admission:	Date of Discharge:

Patient's Medical Information

1) Please provide full and exact details of the diagnosis.	2) Was the patient referred by any other doctor or hospital? ☐ Yes ☐ No If yes, please state name of the doctor and hospital.
3) Date of injury or symptom(s) first appeared: (DD/MM/YY)	(a) Date of first consultation with you: (DD/MM/YY) (b) Reasons for referral?

4) Please state the symptoms presented during the first consultation.

a) How long had the symptoms/complaints existed:

(i) According to the patient ? _____Day/s_____Week/s_____Month/s_____Year/s

(ii) In your medical opinion? _____Day/s_____Week/s_____Month/s_____Year/s

5) What was the underlying cause? (Please tick (/) if applicable)	6) To your best knowledge, has the patient ever had the same or similar condition(s) or symptom(s)?
☐ Idiopathic ☐ Alcohol abuse ☐ Others: _____ ☐ Autoimmune ☐ Toxin _____ ☐ Trauma ☐ Infection _____ ☐ Drug abuse	☐ Yes ☐ No If yes, please state dates and conditions/symptoms.

7) Please complete this portion (tick (/) where applicable), if patient was diagnosed with any of the illnesses below:

☐ **Multiple Sclerosis**

The diagnosis must be confirmed by a Consultant Neurologist and supported by all the following:

- Investigations which confirm the Diagnosis to be Multiple Sclerosis;
- Multiple neurological deficits resulting in impairment of motor and sensory functions occurring over a continuous period of at least 6 months; and
- Well documented history of exacerbations and remissions of said symptoms or neurological deficits.

☐ **Alzheimer's Disease/Severe Dementia**

The diagnosis must be clinically confirmed by a Neurologist Doctor.

(i) Is there evidence of deterioration or loss of intellectual capacity or abnormal behaviour resulting in significant ☐ Yes ☐ No

If "Yes", please describe the findings:

_____

_____

(ii) Is the condition irreversible? ☐ Yes ☐ No
If "No", kindly provide details:

_____

_____

(iii) Is the brain disorder organic? ☐ Yes ☐ No
'If "No", kindly provide details.

_____

Alzheimer's Disease/Severe Dementia (Cont.)

(iv) Is the deterioration or loss of intellectual capacity or abnormal behaviour arise from neurosis, psychiatric, illness, any drug or alcohol related brain damage?

☐ Yes ☐ No

If "Yes", please give details:

_____

_____

(v) Please state if there is anything in the Patient's family history which would have increased the risk of this illness?

_____

_____

☐ **Motor Neuron Disease - Permanent Neurological Deficit with persisting clinical symptoms**

(i) Kindly select the type of Motor Neuron Disease:

☐ Amyotrophic lateral sclerosis ☐ Primary lateral sclerosis
☐ Progressive bulbar palsy ☐ Spinal muscular atrophy

(ii) Are there any definite evidence of appropriate and relevant neurological signs supporting the diagnosis?

☐ Yes ☐ No

If "Yes", please elaborate:

_____

_____

_____

(iii) Were there Permanent Neurological Deficit with persisting clinical symptoms?

☐ Yes ☐ No

☐ **Stroke - Resulting in Permanent Neurological Deficit with Persisting Clinical Symptoms**
The diagnosis must be certified by a Neurologist Doctor.

Please tick (/) if the patient met the following criteria:

☐ Death of brain tissue due to inadequate blood supply, bleeding within the skull or embolization from an extra cranial source resulting in Permanent Neurological Deficit with persisting clinical symptoms

☐ Patient suffered from a neurological sequela which lasted not less than 3 months

Please comment on any neurological sequela which had lasted not less than 3 months :

_____

_____

(i) Are these sequela permanent?

☐ Yes ☐ No

(ii) Was the diagnosis based on changes seen in a CT scan or MRI?

☐ Yes ☐ No

(iii) Please tick (/) if the diagnosis falls under any of the following:

☐ Transient Ischemic attacks

☐ Cerebral symptoms due to migraine

☐ Traumatic injury to brain tissue or blood vessels

☐ Vascular disease affecting the eye or optic nerve or vestibular functions

☐ None of the above

☐ **Bacterial meningitis - Resulting in Permanent Inability to Perform Activities of Daily Living**

☐ **Encephalitis - Resulting in Permanent Inability to Perform Activities of Daily Living**

The diagnosis must be certified by a Neurologist Doctor or by an appropriate specialist doctor.

Please tick (/) if the patient met the following criteria as per the critical illness:

☐ Bacterial meningitis - causing inflammation of the membranes of the brain or spinal cord resulting in Permanent functional impairment

☐ Encephalitis - severe inflammation of brain substance, resulting in Permanent functional impairment

(i) Was there any significant and serious permanent neurological deficit?
☐ Yes ☐ No

(ii) Is the permanent neurological deficit:

(a) documented for more than 30 days? ☐ Yes ☐ No

(b) resulting in any inability to perform at least three (3) of the Activities of Daily Living?
☐ Yes ☐ No

(c) Which of the following daily activities is the patient **NOT** able to perform?
Please check (/) the appropriate item:

☐	Getting in and out of a chair without requiring physical assistance.
☐	Putting on and taking off all necessary items of clothing without requiring assistance of another person.
☐	The ability to move from room to room without requiring any physical assistance.
☐	The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene.
☐	The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means.
☐	All tasks of getting food into the body once it has been prepared.

(iii) Is such inability expected to be permanent? ☐ Yes ☐ No

(iv) Is the Patient HIV Positive? ☐ Yes ☐ No

(v) For bacterial meningitis, is there a presence of bacterial infection in the cerebrospinal fluid by lumbar puncture?
☐ Yes ☐ No

☐ **Major Head Trauma - resulting in permanent inability to perform Activities of Daily Living**

(i) What is the exact location and extent of the head injury?

_____

_____

(ii) Which of the following Daily Activities is the patient **NOT** able to perform as a direct result of the trauma?

☐	Getting in and out of a chair without requiring physical assistance.
☐	Putting on and taking off all necessary items of clothing without requiring assistance of another person.
☐	The ability to move from room to room without requiring any physical assistance.
☐	The ability to voluntarily control bowel and bladder functions such as to maintain personal hygiene.
☐	The ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by any other means.
☐	All tasks of getting food into the body once it has been prepared.

(iii) How long has such inability been medically documented?

_____

_____

(iv) Is such inability expected to be permanent? ☐ Yes ☐ No

☐ **Brain surgery**

(i) Did the patient undergo surgery of the brain ?

☐ Yes ☐ No

If "Yes", please state the type of surgery conducted:

_____

(ii) Reason for surgery:

_____

_____

(iii) Was the brain surgery a result of an accident?

☐ Yes ☐ No

(iv) Name the nature of the procedure.

_____

Please state the date of the surgery (DD/MM/YY)

_____

(v) Which of the following operations procedure was done?

☐ Burr hole
☐ Transphenoidal
☐ Endoscopic assisted procedures or any other minimally invasive procedures
☐ Others :

_____

_____

8) Has the Patient suffered from or/been treated for any other illnesses or complaints other than this critical illness?

☐ Yes ☐ No

If "Yes", please give details:

9) If there is any further information which is in your opinion will assist us in assessing the claim, please furnish us with such information.

Please enclose copies of ALL the relevant Laboratory evidences/tests for the respective critical illness claim.

Multiple Sclerosis	CT Scan/MRI Report of the Brain and Spine, Nerve conduction study/Evoked potential test, Assessment report by Consultant Neurologist
Alzheimer's Disease / Severe Dementia	Clinical evaluation and imaging test and all relevant investigation results in support of the diagnosis
Stroke	CT Scan/MRI Report of the Brain, Assessment report by Consultant Neurologist and all other reports to support the diagnosis.
Bacterial Meningitis/ Encephalitis	CT Scan/MRI Report of the Brain & Spine, Lumbar puncture test report and all other reports to support the diagnosis.
Brain surgery	Brain Surgery report, CT scan/MRI of the brain (Pre and post Surgery, if any)
Motor Neurone Disease	All post operative reports, X-rays, CT scan/MRI report of the Brain and Spine, Electromyography (EMG) test results and all relevant investigation results to support the diagnosis.
Major Head Trauma	CT scan/MRI report of Brain, Surgery report, Neurologist report to confirm the permanent functional result in an inability (to perform at least 3 out of 6 Activities of Daily Living as stated in Policy) and Police report, if any.

Declaration

I hereby certify that the facts given above are true to the best knowledge.

Signature and Stamp:	Name of attending physician/specialist:	Date:
Qualification:	Telephone No:	Hospital: