Claim No.: _____

MEDICAL ATTENDANT'S REPORT ON TOTAL AND PERMANENT DISABILITY CLAIM

This report is to be completed by the registered medical practitioner at the own expense of Participant / Claimant.

1. a) Name of Participant.	a)
b) I/C No.	b) Old: New:
c) Date of Birth.	c)
d) Occupation at time of disability.	d)
e) Takaful Certificate No.	e)
2. a) Date when disability began.	a)
b) Cause of disability.	b)
c) If disability was due to accident, please provide:	c)
i) Date of accident.	i)
ii) Time.	ii) AM PM
iii) Full circumstances of the accident.	iii)
d) If disability was due to illness, please provide:	d)
i) Diagnosis.	i)
ii) Date when diagnosis was first established.	ii)
iii) Date when patient was first informed of the diagnosis.	iii)
iv) Name and address of doctor who first established the diagnosis.	iv)
3. Please provide dates of consultation and names and addresses of all doctors consulted by this patient for this condition/disability as follows:	
a) Doctor first consulted.	a)
b) All doctors subsequently consulted.	b)

4. Please give details of the clinical and physical findings noted by you on: a) Date of patient's first consultation with you. b) Last date of consultation.	 a) b)
5. a) Type of treatment and advice being given or this condition / disability. b) Type of surgery being performed and date of surgery. c) Type of treatment that is still on going.	a) b) c)
6. Please state all the complaints and disabilities that the patient still claims to suffer from currently or on date of his / her last consultation with you:	
7. a) Has the patient's condition improved, deteriorated or remained the same on last consultation date? b) Is there any rehabilitation that would help to improve the patient's condition? If so, please give details. c) Is the patient's current condition / disability expected to be permanent? d) If the condition is not permanent, to what extent is recovery expected and when is recovery expected to begin?	a) b) c) d)
8. a) If patient's condition is permanent, would the condition prevent the patient from: i) Performing his / her own occupation only? ii) Performing patient's own occupation and also any other occupation? b) Please state the date when patient is medically boarded out, if any.	a) i) ii) b)

9. Has the patient ever been diagnosed / suffered from any of the following:	
a) Hypertension.	a)
b) Diabetes Mellitus.	b)
c) Cardiovascular Disease.	c)
d) Same / similar condition previously.	d)
e) Other illness(es) / Injuries.	e)
If so, please provide diagnosis, date of diagnosis / onset, names and addresses of all doctors consulted and dates of consultation.	
10. Please give any other information which you feel would be helpful in the assessment of your patient's claim.	

11. Please assess the patient's degree of limitation in performing the activities specified in the table below (ticking the appropriate columns).
On a separate sheet, please provide any additional comments which, in your opinion, will serve to clarify the Participant's functional ability.

Date of Functional Assessment:

Activity	Current Ability					Expected Ability in 12 Months			Expected Long Term Ability		
	No Limitation	Mild Limitation	Moderate Limitation	Severe Limitation	Totally Incapable	Improve	Deteriorate	Totally Incapable	Improve	Deteriorate	Totally Incapable
Standing											
Kneeling											
Bending											
Sitting											
Hearing											
Eating											
Climbing stairs											
Lifting & carrying											
Walking (non strenuous) over level ground											
Dressing											
Fine motor co-ordination											
Interacting with others											
Sedentary tasks											
Clerical / administrative tasks											
Operating light machinery											
Operating heavy machinery											
Working with light weights											
Working with heavy weights											
Driving a light motor vehicle											
Driving a heavy motor vehicle											

Activity	Current Ability					Expected Ability in 12 Months			Expected Long Term Ability		
	No Limitation	Mild Limitation	Moderate Limitation	Severe Limitation	Totally Incapable	Improve	Deteriorate	Totally Incapable	Improve	Deteriorate	Totally Incapable
Light manual labour											
Heavy manual labour											
Working in a cramped environment											
Working in a dusty environment											
Working in a smoky environment											
Right Hand											
Left Hand											
Right Knee											
Left Knee											
Right Arm											
Left Arm											
Right Elbow											
Left Elbow											
Range of movement of Neck towards Right Neck											
Range of movement of Neck towards Left Neck											

I hereby certify that I have personally examined the patient for the above TPD asessment on _____(dd mm yyyy) and that the facts as stated above represent my medical opinion of his / her condition.

Signature: _____
Name (in block capitals please): _____
Official Stamp :

We would be most grateful if you could send copies of any specialist or hospital reports, together with any tests, readings, or similar evidence to support the validity of your patient's claim.

Official Stamp:

Signature: _____

Name (in block capitals please): _____

Qualification: _____

Date: _____

For Office Use Only

Checked and Verified By: _____ Date: _____Branch: _____
(Name of Staff)