AmMetLife Takaful Berhad (931074-V) Licensed Takaful Operator
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AmMetLife Takaful

HOSPITALISATION CLAIM - ATTENDING PHYSICIAN'S STATEMENT

To be completed by the Doctor who treated the Participant during hospitalization at Participant's expense

1. PARTICULARS OF THE PATIENT

a. Name : _____

b. Identity Card No : _____ Age : _____

c. Date of Birth : _____ Gender : Male ☐ Female ☐

2. DETAILS OF HOSPITALISATION

a. Admission No. : _____

b. Date of Admission : _____ Time : _____am / pm

c. Date of Discharge : _____ Time : _____am / pm

3. IF HOSPITALISATION DUE TO ACCIDENT, PLEASE FURNISH

a. When did it happen? : DD:_____MM:_____YY:_____at:_____am/pm

b. Where did it happen? : _____

c. Nature of accident : _____

_____

4. The date on which you first saw the patient for this illness / injury / condition.

Was the patient referred to your hospital by any other doctor?

☐ Yes ☐ No

If Yes, please indicate his / her name and address.

Doctor's Name : _____

Address : _____

_____

_____

5. What were the symptoms the patient complained when he / she first saw you?

According to patient, how long has he / she been experiencing these symptoms?

How long do you feel this symptom has lasted?

6. Had patient previously received any treatment for the above symptoms?

☐ Yes ☐ No

If Yes, please furnish the name and address of doctors, and date of consultation(s).

Doctor's Name : _____

Doctor's Address : _____

_____

Date of Consultation(s) : _____

7. Have any investigation, test or procedure been performed?

☐ Yes ☐ No

If Yes, please furnish a certified true copy of the result.

Date	Investigation, test or procedure

8.	What was the final diagnosis?	Did you inform the patient of the diagnosis? ☐ Yes ☐ No If Yes, when? Date :
9.	Please state the nature of medical treatment given.	For surgery : Nature of operation performed (MMA Code) : _____ Name of surgeon : _____ Date of surgery performed : _____

10. Has the patient previously been treated or hospitalised in this hospital or any other hospital for this or any other disease? If Yes, please state.

☐ Yes ☐ No

Date	Hospital / Clinic	Disease / Illness

11. **For female only:**

Was the patient pregnant at the time of the hospitalisation? ☐ Yes ☐ No

If Yes, for how months? _____ Months

Was the illness caused directly or indirectly by pregnancy / childbirth / caesarian / abortion miscarriage and all complications arising thereform?

☐ Yes ☐ No

12. Kindly advise whether the patient is presently on dialysis or recommended for dialysis.

a. Date first dialysis done : _____

b. Frequency / Number of days per week : _____

c. Dialysis centre name : _____

13. Kindly advise whether the patient may require any follow-up treatment for cancer

a. Type of follow-up treatment: ☐ Chemotherapy ☐ Radiotherapy

b. Course of treatment recommended:

_____

_____

c. Duration of treatment
Date started : _____ Date ended : _____

d. No. of session to be completed : _____

DECLARATION

I hereby certify that the information given above are full, complete and true to the best of my knowledge.

Name of Physician : _____

Telephone No. : _____

Qualification / Rank : _____

Date : _____

Signature &
Clinic / Hospital Stamp : _____