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

STROKE

DOCTOR'SSTATEMENT

Kindly answer all questions completely as this will assist us to assess the claim accurately, fairly and promptly. We appreciate your co-operation.
The cost of this report is borne by the applicant.

Patient's Name :	Patient's I/C Number :	Passport Number :	Certificate Number :

A	**General Information**	
1	Are you patient's usual medical doctor? If Yes, ever what period does your record extend to?	Yes ☐ No ☐ Date Month Year _____ / _____ / _____
2	When did the patient first consult you for this condition?	Date Month Year _____ / _____ / _____
3	What were the symptoms and their duration? _____ _____ Please state the date of onset of first occurrence of symptoms.	Date Month Year ____ / ____ / ____
4	In your opinion, what were the likely duration of the patient's symptoms? Please provide reasons. _____ _____	
5	Did the patient consult any other doctor for those symptoms before she/he consulted you? If Yes, please provide the details below.	Yes ☐ No ☐

Doctor's Name	**Clinic/hospital's Name**	**Diagnosis Date**	**Treatment Date**

B	**Details of Critical Illness**	
6	Please provide full details of the diagnosis. _____ _____ Please state the date of diagnosis.	Date Month Year ____ / ____ / ____
7	Please provide the name of the doctor and clinic/hospital where the diagnosis was first made. _____ _____	

8	When was the patient first made aware of diagnosis? Date Month Year ____ / ____ / ____
9	Has there been an infraction of brain tissue, hemorrhage of embolization from an extra cranial source? _____ _____
10	Date of initial episode? Date Month Year ____ / ____ / ____
11	How long has the neurological damage lasted since the initial episode? Please provide duration in days/weeks. _____
12	Please provide a description of the neurological damage. Is this neurological damage permanent? _____ _____
13	What are the Insured's current physical and/or mental limitations? _____ _____
14	Date of return to normal activities? Date Month Year ____ / ____ / ____
B	**Details of Critical Illness (Continued)**
15	Please provide details of all investigations/test performed and enclose certified true copies of all reports, e.g. CT scan and MRI scan reports and other relevant hospital reports. _____ _____
16	Are the investigation findings consistent with the diagnosis of a new stroke? Yes ☐ No ☐
17	Please provide the names of the doctors together with the names and address of the hospital / clinic for which the patient had attended for this condition. _____ _____
C	**Medical History**
18	Has the patient previously suffered from stroke or any related illnesses (e.g. hypertension, transient ischemic attack, angina and other cardiovascular diseases? Yes ☐ No ☐ If yes, please provide details. _____ _____
19	Please give details of the patient's family history which would have increased the risks of having a Stroke (including the relationship, nature of illness, date of diagnosis and source of information). _____ _____
20	Please give details of the patient's habits in relation to past and present smoking, including the duration of smoking habits, number of cigarettes smoked per day and source of this information. _____ _____
21	Please give details of the patient's habits in relation to alcohol consumption, including the amount of alcohol consumption per day and source of this information. _____ _____

22	Does the patient have or ever had any other significant health conditions? Yes ☐ No ☐ If yes, please provide details of the illnesses, including diagnosis, date of diagnosis and treatment given. _____ _____
23	Any other information you feel may be relevant. _____ _____

I hereby declare that foregoing answers are true to the best of my knowledge and option.

Name: _____

Qualification: _____

Tel. No.: _____ Date: _____

Address: _____

_____

Clinic/ Hospital stamp: Signature: