MEDICAL REPORT
(DEATH CLAIM)

To be completed by the physician who last attended to the deceased at Claimant's expense.

DECEASED INFORMATION

1. Deceased's name in full	1) _____
2. I/C No.	2) New _____ Old _____
3. Age / Sex	3) Age _____ ☐ Male ☐ Female
4. Occupation prior to death	4) _____

FACTS OF DEATH

5. Date & place of death	5) _____ *(DD/MM/YY)* at _____ am/pm Place _____
(i) Immediate cause of death	(i) _____
(ii) Intervening cause of death	(ii) _____
(iii) Primary cause of death	(iii) _____
(iv) Other significant disease(s) contributing to the death, please specify	(iv) _____
6. Were there any predisposing cause(s) of the deceased's death in relation to his/her habit (use of alcohol, nicotine, their quantity & etc), family history, occupation or previous disease ?	6) _____
7. Was a Coroner's inquest or post-mortem conducted on the body of the deceased or any Toxicology analysis required?	7) Coroner's Inquest ☐ Yes ☐ No Post-Mortem ☐ Yes ☐ No Toxicology ☐ Yes ☐ No

IF DEATH WAS DUE TO ILLNESS

8. Were you the deceased's usual medical attendant ? If so, since when? If not, please give the name & address of the deceased's usual medical attendant if known to you.	8) ☐ Yes, since _____ *(DD/MM/YY)* ☐ No Name _____ Address _____

9. Please state from your records the injuries and illness from which your patient has been treated at your hospital/clinic.

Date	Diagnosis	Treatment

Head Office : Level 29, Menara Allianz Sentral, 203, Jalan Tun Sambanthan, Kuala Lumpur Sentral, 50470 Kuala Lumpur.
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10. Did you attend to the deceased during his/her last illness?	10) ☐ No ☐ Yes
11. Was the illness found out during a routine medical check-up? If so, when?	11) ☐ No ☐ Yes _____ (*DD/MM/YY*)
12. Date you were first consulted for the illness.	12) Date _____ (*DD/MM/YY*)
13. Was the deceased referred to you by any other doctor? If so, please give the name & address of doctor and enclose a copy of the referral letter.	13) ☐ No ☐ Yes Name _____ Address _____
14. What were the symptoms complained?	14) _____
15. How long had he/she had experiencing these symptoms prior to consulting you?	15) _____
16. How long, to your knowledge, did the deceased suffer from this medical condition and was he/she under any treatment/ medication?	16) _____
17. When and where was the medical condition first diagnosed? Kindly furnish us a copy of the investigation report confirming the diagnosis.	17) Date _____ (*DD/MM/YY*) Place _____ Diagnosis _____
18. When was the deceased first informed of the diagnosis?	18) Date _____ (*DD/MM/YY*)

GENERAL INFORMATION

19. Please state name(s) and address(es) of any other practitioner whom had attended to the deceased.

Date	Name & address of the Doctor	Disease & treatment

20. Please give any other information which you feel may be relevant to the death claim.

Please give any other information which you feel may be relevant to the death claim.

Signature
Date

Name & Qualification

Hospital/Clinic Stamp Print

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LAPORAN PERUBATAN
(TUNTUTAN KEMATIAN)

Untuk diisikan oleh pakar perubatan yang terakhir merawat si mati atas perbelanjaan pihak yang menuntut.

MAKLUMAT SI MATI

1. Nama penuh si mati	1) _____
2. No K/P	2) Baru _____ Lama _____
3. Umur/Jantina	3) Umur _____ ☐ Lelaki ☐ Perempuan
4. Pekerjaan sebelum kematian	4) _____

FACTS OF DEATH

5. Tarikh & tempat kematian	5) _____ *(HH/BB/TT)* at _____ pagi/ptg Tempat _____
(i) Sebab terdekat kematian	(i) _____
(ii) Sebab mencelah kematian	(ii) _____
(iii) Sebab utama kematian	(iii) _____
(iv) Lain-lain penyakit penting yang menyumbang kepada kematian, sila nyatakan	(iv) _____
6. Adakah terdapat apa-apa sebab/(sebab-sebab) yang mempradispose kematian si mati berhubungan dengan tabiat beliau (penggunaan alkohol, nikotin, kuantitinya dll), sejarah keluarga, pekerjaan atau penyakit terdahulu beliau.	6) _____
7. Adakah inkues Koroner atau bedah-siasat dijalankan ke atas tubuh si mati atau sebarang analisa Toksikologi diperlukan ?	7) Inkues Koroner ☐ Ya ☐ Tidak Bedah-Siasat ☐ Ya ☐ Tidak Toksikologi ☐ Ya ☐ Tidak

SEKIRANYA KEMATIAN DISEBABKAN OLEH PENYAKIT

8. Adakah anda merupakan doktor bertugas biasa yang merawat si mati ? Jika ya, sejak bila ? Jika tidak, sila nyatakan nama & alamat doktor bertugas yang biasa merawat si mati sekiranya anda tahu.	8) ☐ Ya, sejak _____ *(HH/BB/TT)* ☐ Tidak Nama _____ Alamat _____

9. Sila nyatakan berdasarkan rekod-rekod anda kecederaan dan penyakit untuk yang mana pesakit anda telah dirawat di hospital/klinik anda.

Tarikh	Diagnosis	Rawatan

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10. Adakah anda yang merawat si mati semasa penyakit terakhirnya?	10) ☐ Tidak ☐ Ya
11. Adakah penyakit ditemui semasa pemeriksaan perubatan rutin? Jika ya, bila?	11) ☐ Tidak ☐ Ya _____ (HH/BB/TT)
12. Tarikh pertama kalinya anda diminta merawat penyakit ini.	12) Tarikh _____ (HH/BB/TT)
13. Adakah si mati dirujukkan kepada anda oleh mana-mana doktor lain ? Jika ya, sila nyatakan nama & alamat doktor tersebut dan lampirkan satu salinan surat rujukan.	13) ☐ Tidak ☐ Ya Nama _____ Alamat _____
14. Apakah simtom yang diadukan?	14) _____
15. Berapa lamakah beliau mengidap simtom ini sebelum menjumpai anda?	15) _____
16. Berapa lamakah dalam pengetahuan anda, si mati mangalami keadaan ini dan adakah beliau di bawah apa-apa rawatan/ pengambilan ubat?	16) _____
17. Bilakah dan di manakah keadaan ini pertama kalinya didiagnosiskan ? Sila kemukakan kepada kami satu salinan laporan penyiasatan mengesahkan diagnosis ini.	17) Tarikh _____ (HH/BB/TT) Tempat _____ Diagnosis _____
18. Bilakah si mati pertama kalinya diberitahu mengenai diagnosis ?	18) Tarikh _____ (HH/BB/TT)

MAKLUMAT AM

19. Sila nyatakan nama (nama-nama) dan alamat (alamat-alamat) pengamal perubatan yang merawat si mati.

Tarikh	Nama & alamat Doktor	Penyakit & rawatan

20. Sila nyatakan apa-apa maklumat lain yang anda rasakan berkaitan dengan tuntutan kematian.

Saya dengan ini mengisytiharkan bahawa jawapan-jawapan di atas adalah benar setakat pengetahuan terbaik saya.

Tandatangan Tarikh	Nama & Kelayakan	Cop Hospital/Klinik

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