Allianz

Allianz Life Insurance Malaysia Berhad 198301008983 (104248-X)
(Licensed under the Financial Services Act 2013 and regulated by Bank Negara Malaysia)

Medical Report (Personal Accident Claim)

To be completed by a legally qualified and registered doctor at the life assured's expenses

Policy No. : _____

Personal Details Of Patient

Name of Patient:		Age:	
New NRIC / Passport No.:		Sex:	☐ Male ☐ Female
Occupation:			
Nature of Occupational Duties:			

Accident Details

1.	Date of accident: D D / M M / Y Y Y Y	Time of accident (AM/PM): _____
2.	Nature of accident: _____	

Injury Details

1.	Date you first saw the patient for this condition:	D D / M M / Y Y Y Y
2.	Was the patient being referred to you? If yes, please indicate name and address of the referral doctor.	☐ No ☐ Yes
3.	Was there any external and visible injury or wound as a result of the accident?	☐ No ☐ Yes
	(a) If yes, kindly describe the type and extent of injuries including site and other characteristics and features.	
	(b) If no, kindly describe any other evidence that is consistent with the accident as claimed by the patient.	

4. In the event of amputation, kindly provide details.

Site	Level of Amputation *(e.g. proximal, middle, distal)*	Percentage of Loss (%)

5.	What was your final diagnosis established?	

6.	Was patient's current injury consistent with the nature of the accident? If no, kindly describe if the injury is traceable to any pre-existing conditions, previous injuries not related to this accident, or any other causes *(e.g. exertion, overuse, repetitive movement, etc.)* known to you.	
7.	Was the injury related directly, indirectly, partly or wholly to: (a) Congenital defect or disease (b) Alcohol or drug abuse	☐ No ☐ Yes ☐ No ☐ Yes

8. Kindly provide details of the investigation test or imaging done that confirms the diagnosis.

Date	Type of Investigation	Investigation Result

9. Kindly provide details of the progress and treatment given including all follow-up treatment(s):

Date	Details/Condition of Injury	Healing Progress *(e.g. wound condition, range of movement, pain level, limb power, etc.)*	Treatment *(e.g. dressing, physiotherapy, medication, etc.)*

10.	Was patient put on any form of immobilisation *(e.g. backslab, crepe bandage, etc.)*? If yes, kindly provide details.	☐ No ☐ Yes
	(a) Date first applied?	D D / M M / Y Y Y Y
	(b) Date removed?	D D / M M / Y Y Y Y
	(c) Date first started on physiotherapy?	D D / M M / Y Y Y Y
	(d) Date first started on full weight bearing exercise?	D D / M M / Y Y Y Y
	(e) Last date of physiotherapy? Kindly provide details of limitation of movement on any joint.	D D / M M / Y Y Y Y

11. Was there any surgical procedure performed? If yes, kindly provide details.

Date	Type of Surgery	Surgeon/Hospital

12. Date you last saw the patient for this condition.
Kindly provide condition of the injured part.

D D / M M / Y Y Y Y

13. Was healing straight forward or complicated?
Kindly provide details of the complication *(if any)*.

14. Was there any physical impairment or disease which may likely to retard patient's recovery? If yes, kindly provide details.

15. Please give the details of all other treating doctors, whom had attended to the patient for this condition.

Date	Diagnosis	Treatment	Doctor/Hospital

Declaration

I hereby certify that I have personally examined and treated the patient for his/her illness/condition/injury described and the facts stated above represent my medical opinion of his/her condition. I declare that I have not withheld any material information or fact. The above information is full, complete and true as per record from the hospital/clinic. I further understand that my report may form part of the evidence in any medico legal assessment.

Signature and Official Stamp of Attending Doctor

Hospital / Clinic Official Stamp

Name of Attending Doctor:

Qualification / Specialty :

Date (DD/MM/YYYY) :

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