MEDICAL ATTENDANT'S REPORT

(to be completed by deceased's attending doctor)

DECEASED'S PARTICULARS			
Name of deceased			
NRIC/ Passport No.		Date of birth	(DD/MM/YY)

MEDICAL RECORDS			
1.	Are you the insured's usual doctor?		Yes / No
2.	Over what period do your records extend? Start date: _____ (DD/MM/YYYY)		End date: _____ (DD/MM/YYYY)
3	Did you attend to the deceased's last illness? If yes, please provide the details below		Yes / No
a.	What were the symptoms presented?		
b.	When did the symptoms first started?		_____ (DD/MM/YYYY)
c.	What was the diagnosis?		
d.	Date diagnosis was made known to the deceased		_____ (DD/MM/YYYY)
e.	What were the treatment administered and the period of treatment?		
4.	Was the illness under (3) above caused by any other underlying disorders? If yes, please provide the details below:		Yes / No
	Illness/ Disorder	Date of diagnosis	Name and address of treating doctor
5.	Please provide the name and address of the deceased's regular attending doctor.		

DETAILS OF DEATH				
1.	What is the cause of death?			
2.	What is the interval between onset and death?			
3.	Please state the name and address of the doctor who treated the deceased for this condition.			
4.	Please provide details of any other significant illness that the deceased suffered from:			
	Illness/ Medical Condition	Date of Diagnosis	Name and address of doctor consulted	
5.	Was the deceased's death arising from any predisposing habit (such as use of alcohol, narcotics etc), family history, occupation or previous sickness? If yes, please provide details including when it started, doctors consulted, blood alcohol content, drug type and quantity consumed.			Yes / No
6.	Was the deceased's death due to suicide, self-destruction or intentional self-inflicted injury? If yes, please provide details.			Yes / No
7.	Was the cause of death due to accident? If yes, please provide the details below:			Yes/ No
a.	Place of accident			Date of accident (DD/MM/YYYY)
b.	Please describe how the accident occurred.			
c.	Please describe the nature and extent of injuries sustained.			
8.	Please provide us with any other information that you feel may be useful.			

Name of doctor: _____

Date completed: _____ Doctor's Official Stamp: _____

Name of clinic/ hospital: _____