Sun Life Malaysia Assurance Berhad* (197499-U)
Sun Life Malaysia Takaful Berhad* (689263-M)
Level 11, 338 Jalan Tuanku Abdul Rahman, 50100 Kuala Lumpur.
Telephone : (603) 2612 3600 Fascimile : (603) 2698 7035
Customer Careline : 1300-88-5055 sunlifemalaysia.com

CRITICAL ILLNESS (KIDNEY DISEASE) - MEDICAL REPORT

1. The following named is covered with **SUN LIFE MALAYSIA** against the happening of certain contingents events associated his/her health. A claim submitted in connection with KIDNEY DISEASE and to enable us to assess the claim, we would be obliged if you would complete this Medical Report.
2. Any fees chargeable for the completion of this form shall be borne by the patient/ claimant.

Policy / Certificate / Contract No. : ____________________

Name of Patient : ____________________

NRIC / Birth Certificate No. / Passport No. : ____________________

Please attach certified true copies of all the relevant medical/laboratory tests available.

☐ Dialysis report ☐ Cystoscopy ☐ Ultrasound

☐ Blood test results ☐ Other reports : ____________________

1. (a) Are you the patient's regular attending doctor? ☐ Yes ☐ No

   (b) Since when has the patient been consulting you? Date : ____________ (dd/mm/yyyy)

   (c) Was the patient referred to you? ☐ Yes ☐ No

   (i) Referral Date : ____________ (dd/mm/yyyy)

   (ii) Referral Doctor : ____________________

   (iii) Clinic / Hospital : ____________________

   (iv) Referral Reason : ____________________

   **Kindly furnish us a copy of the referral letter*

   (d) Please state the symptoms presented during the date of **FIRST** consultation and for how long the patient had been experiencing these symptoms.

Onset date (dd/mm/yyyy)	Symptoms

(Please use separate sheet if space provided is insufficient)

2. (a) Please state the full and exact diagnosis.

   Diagnosis : ____________________

   (b) When was it **FIRST** diagnosed? Date : ____________ (dd/mm/yyyy)

   (c) What was the underlying cause? ____________________

   (i) When was the patient **FIRST** diagnosed with the above illness? ____________ (dd/mm/yyyy)

   (ii) Please state the full diagnosis : ____________________

   (iii) Diagnosed by whom? Please give details.

   Doctor's Name : ____________________ Clinic / Hospital : ____________________

   (d) Is the patient having renal failure? ☐ Yes ☐ No

   If yes, please provide the answer for the following (s):

   (i) Has the patient's renal disease reached end-stage? ☐ Yes ☐ No

   If yes, please state the date : ____________ (dd/mm/yyyy)

   (ii) Which kidney(s) is involved? ☐ Right ☐ Left ☐ Both

   (iii) Is the failure of the kidney functions presented as chronic irreversible? ☐ Yes ☐ No

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(iv) Is the patient undergoing regular peritoneal dialysis or haemodialysis ? ☐ Yes ☐ No
If yes, please state the **FIRST** dialysis date : ____________________ (dd/mm/yyyy)

(v) Please state the frequency of required dialysis per week : ____________ per week

(vi) Has renal transplant been performed? ☐ Yes ☐ No
If yes, please state :

Date : ___________________ (dd/mm/yyyy) Hospital : ____

3. Is the patient's kidney disease due to Systemic Lupus Erythematosus (SLE)? ☐ Yes ☐ No

(a) If yes, please indicate the WHO classification of the Type of Lupus Nephritis as confirmed by renal biopsy :

☐ Type I – Minimal change glomerulonephritis

☐ Type II – Mesangial glomerulonephritis

☐ Type III – Focal Segmental glomerulonephritis

☐ Type IV – Diffuse glomerulonephritis

☐ Type V – Membranous glomerulonephritis

(b) Does the SLE involves any of the following areas or organs?

☐ Blood ☐ Joints ☐ Kidneys ☐ Skin

☐ Lungs ☐ Others : ___________________________

(c) When was the **FIRST** abnormal blood test detected? Date : _______________ (dd/mm/yyyy)
Clinic / Hospital :____

(d) Was the patient informed of the abnormal blood test results? ☐ Yes ☐ No
If yes, please state date. Date : ________________________ (dd/mm/yyyy)

(e) Was the patient advised to perform additional tests when the above abnormal results were detected? ☐ Yes ☐ No

If Yes, (i) Date : _______________ (dd/mm/yyyy)
(ii) Test : ____
(iii) Results : ____
Please attach a certified copy of the test results

(f) If copies of Renal Function Test results are not available, please state detailed results and dates below :

Renal Function Test	Date : ___________	Date : ___________	Date : ___________	Date : ___________
Serum creatinine				
Serum urea				
eGFR				
Urine FEME				
Others (*please specify*)				

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4. Has the patient suffered from/been treated for any other illnesses related to / causing this Critical Illness? ☐ Yes ☐ No

   If yes, please give full details :

Date	Diagnosis	Treating clinic / hospital		Treatment

(Please use separate sheet if space provided is insufficient)

5. (a) Has the patient suffered from the following or any related illnesses previously? Please give details.

Diagnosis	Yes / No	Onset date (dd/mm/yyyy)	Treating clinic / hospital
Hypertension	☐ Yes ☐ No		
Diabetes Mellitus	☐ Yes ☐ No		
Dyslipidaemia	☐ Yes ☐ No		
Heart Disease	☐ Yes ☐ No		
Liver Disease	☐ Yes ☐ No		
Others (please specify) :			
Others (please specify) :			

(b) If the patient was diagnosed to have Hypertension, Diabetes Mellitus or Dyslipidaemia, please state the recorded blood pressure, lipid profile or blood glucose level taken on him/her starting from the first recording done.

Date (dd/mm/yyyy)	Blood Pressure Reading	Blood Glucose Level (fasting)	Lipid Profile

(Please use separate sheet if space provided is insufficient)

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(c).Please state from past records or from your personal knowledge, details of all illness, accidents, surgical operations or diseases from which the patient has suffered or for which he/she has been treated at your clinic from the first consultation until last consultation

Date	Complaints & Symptoms	Diagnosis	Treatment

(Please use separate sheet if space provided is insufficient)

6. (a) Please state if there is anything in the patient's family history which would have increased the risk of illness.

____

(b) Has the patient suffered from/been treated for any illnesses related to/cause this critical illness ? ☐ Yes ☐ No

____

(c) What is your prognosis on the patient's condition?

____

(d) Is full recovery expected? ☐ Yes ☐ No

If Yes, please state approximate date : ___________________ (dd/mm/yyyy)

If No, please state the extent of recovery and approximate date of the stated extent of recovery.

(e) Any further information which in your opinion will assist us in assessing the claim?

____

____

____

"I HEREBY CERTIFY THAT THE INFORMATION STATED ABOVE ARE TRUE AND REPRESENT MY PROFESSIONAL MEDICAL OPINION OF HIS/HER CONDITION"

Date: …………………………………………………. Signature : ………………………………………………….

Hospital / Clinic Stamp: ……………………………… Doctor's Name: ……………………………………………

Contact No : ……………………………………………….

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