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 MEDICAL REPORT (HEART RELATED CONDITIONS)

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 HEART 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.

- ☐ All serial Electrocardiogram (ECG)
- ☐ All Cardiac Enzymes (CPK-MB, Troponin T / Troponin I)
- ☐ Percutaneous Coronary Intervention (PCI) Report
- ☐ Other reports : _____
- ☐ Coronary angiogram report
- ☐ Coronary Artery By-pass Graft operation report
- ☐ Cardiac catheterization report

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 exact diagnosis : _____

(e) Diagnosis Date : _____ (dd/mm/yyyy)

(f) What was the underlying cause? _____

(g) 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

2. (a) Was there a history of typical prolonged chest pain? ☐ Yes ☐ No

(i) Date of the first onset of episode : _____ (dd/mm/yyyy)

Please elaborate : _____

_____

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(ii) Was there a serial elevation of cardiac enzyme (CPK-MB) above normal limit? ☐ Yes ☐ No

Please give details of the results :

Date of Cardiac Enzyme taken (dd/mm/yy)	Cardiac Enzyme reading	Reading of normal cardiac enzyme

(iii) Were there any changes in the ECG indicative of a myocardial infarction? ☐ Yes ☐ No

Please elaborate : _____

(iv) Troponin T > 1.0 ng/ml or equivalent threshold with other Troponin I methods? ☐ Yes ☐ No

(b) Was coronary arteriography performed? ☐ Yes ☐ No Date : _____ (dd/mm/yyyy)

Please specify the coronary arteries involved and the percentage of stenosis.

Major Coronary Artery	Percentage (%) of stenosis
Left Anterior Descending (LAD)	
Left Circumflex Artery (LCX)	
Right Coronary Artery (RCA)	

(c) Was Percutaneous Coronary Intervention (PCI) / Angioplasty performed? ☐ Yes ☐ No

Date angioplasty performed : _____ (dd/mm/yyyy)

Please state the artery involved : _____

(d) Was coronary bypass surgery performed? ☐ Yes ☐ No

Date of surgery performed : _____ (dd/mm/yyyy)

Please state the number and sites of grafts inserted : _____

(e) Was heart valve surgery performed? ☐ Yes ☐ No

Date of surgery performed : _____ (dd/mm/yyyy)

(i) The approach was via :

☐ Open heart surgery ☐ Key-hole procedure ☐ Intra-arterial procedure ☐ Valvotomy

(ii) The procedure done was :

☐ Valve replacement ☐ Repair via intra-arterial procedure ☐ Repair via key-hole surgery

(f) Was aorta surgery performed? ☐ Yes ☐ No

Date of surgery performed : _____ (dd/mm/yyyy)

Please state the exact location of the aortic lesion : _____

(i) The approach was via : ☐ Thoracotomy ☐ Intra-arterial procedure ☐ Catheter based techniques

☐ Laparotomy ☐ Key-hole procedure

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(ii) The surgery was performed for : ☐ Aneurysm ☐ Obstruction ☐ Dissection ☐ Coarctation ☐ Others : _____

(iii) The surgery was performed at : ☐ Thoracic aorta ☐ Abdominal aorta ☐ Aortic branches

(iv) Was there any impairment of ventricular function? ☐ Yes ☐ No

Please elaborate : _____

(v) Was there any permanent physical impairment? ☐ Yes ☐ No

Please elaborate : _____

(g) Did the patient undergo any other procedure / surgery? ☐ Yes ☐ No

Procedure / Surgery Date : _____ (dd/mm/yyyy)

Procedure / Surgery Done : _____

(h) Heart Disease Classification (NYHA) :

(i) Please state the severity of cardiac impairment based on New York Heart Association (NYHA) classification

Class : ☐ I ☐ II ☐ III ☐ IV

Please provide details of current limitations : _____

(ii) Is the cardiac impairment likely to be permanent? ☐ Yes ☐ No

(iii) Will the cardiac impairment improve? ☐ Yes ☐ No

Please elaborate. _____

(iv) Details of investigation performed to confirm the diagnosis : _____

_____

(i) Is the patient's heart disease caused by any of the following :

☐ Coronary Artery Disease ☐ Alcohol Misuse ☐ Drug abuse ☐ Congenital

☐ Others (please specify) : _____

3. (a) Has the patient suffered from this illness 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		
Kidney Disease	☐ Yes ☐ No		
Liver Disease	☐ Yes ☐ No		
Others (please specify) :			
Others (please specify) :			

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(b) 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.

4. (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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*A joint venture between Sun Life Assurance Company of Canada and Renggis Ventures Sdn. Bhd.