Hill on Empire Office Park
2nd Floor Building B
Cnr Empire Rd and Hillside Road
Parktown

Postnet Suite 409, Private Bag X30500, Houghton, 2041

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MEDICAL SPECIALIST REPORT:
To be completed by the treating specialist.
Definition of a Terminal Illness:

Terminal illness

If the main insured life is diagnosed with terminal illness and is likely to die within a year, he/she may exercise the option to claim 50% or 100% of the life cover amount. To qualify for payment of the terminal illness benefit, an independent specialist appointed by MiWayLife must confirm the diagnoses and prognosis.

Patient Personal Details:

Policy Number	
Patient's Full Name	
ID Number	

Doctor Details:

Full Name		**Practice Telephone**	

Please supply MiWayLife with copies of all available histology, pathology, x-rays, scans and other tests reports that might be available on the patient file.

History of Consultations

Since when have you been the attending Specialist/ Physician/Oncologist? Please confirm the time the patient was attended at this practice.

Date from: ___/___/____ Date to: ___/___/____

Please provide full details of any doctors, clinics or hospitals that referred the patient to your practice. **Please provide a copy of the referral letter for our perusal**.

Please confirm what was the patient’s symptoms on first consultation?

Please confirm what was the initial diagnosis made on consultation and further tests performed?

What tests were performed to confirm the diagnosis made? Please provide us with copies of all tests performed.

Can you confirm what type of condition was the patient diagnosed with?

Is there any reason to believe that the diagnosis was caused by, or was as a result of, any medical condition, social habit or environmental exposure of the patient, prior to the diagnosis of the cancer? If so, please can you explain?

Please confirm the staging of the diagnosed.

Please specify what special investigations were used to conclude the staging of the condition?

Please provide us with the TNM Staging, if applicable, of the condition as confirmed by testing and staging of condition?

Can you confirm if this diagnosis of the condition was the first diagnosis or was there any previous diagnosis before the recent diagnosis?

Has there been any metastases of the condition to any other organs of the body?

Please provide us with the current treatment plan for the patient

Are there any further treatments planned for the patient? If so, please provide us with the further treatment plan?

What is the prognosis for the patient? **NB**: (**If the prognosis is bad/ guarded, please can you confirm if the life expectancy of the patient is less than 12 months, and the prognosis is considered to be terminal)**

Is the patient currently in remission?

Did the patient suffer from any other chronic medical conditions that needed the use of chronic medication on first consultation? If so, please can you confirm what medical condition the patient was suffering from and what chronic medication the patient was using at the time?

Do you have any further information that you feel important to note?

Please complete the following, include as much detail as possible for ALL consultations and attach all relevant reports such as ECG, Blood laboratory reports, scans or any other special investigations done.

Dates of Consultation	Reason for Consultation	Treatment

Was the patient ever hospitalized or admitted to any institution? Yes No

Duration of Stay (From dd/mm/yyyy to dd/mm/yyyy)	**Reason or presenting symptoms on admission**	**Hospital or Institution name**	**Treatment Details** (Including operations / procedures performed)	**Final Diagnosis**

OTHER DOCTORS:

Are you aware of any other doctors the patient was referred to, or consulted with? **If yes Please complete the following:**

Doctor 1

Doctor's Full Name		
Speciality, if applicable		
Practice Telephone		**E-mail Address**
Cellular		
Dates of consultations		
A short description of the reason for consultation		

Doctor 2

Full Name		
Speciality, if applicable		
Practice Telephone		**E-Mail Address**
Cellular		
Dates of consultations		
A short description of the reason for consultation		

Please note that your report will be treated in the strictest confidence.

Your details

Full Name			
Practice Telephone No.		**E-mail address**	
Practice number		**HPCSA registration number**	
Year of first qualifying		**Qualifications**	

Declaration:

I declare that to the best of my knowledge all information that I have given in this document is accurate and that I have not withheld any information which could influence the decision on this claim. I further declare that I understand that my failure to disclose relevant information in respect of this claim may invalidate the claim. I acknowledge that I fully understand the contents of this declaration.

Signature of the medical attendant	
Signed by	
Signed at	
Signed on the	