

Policy No.	New NRIC No.
No. Polisi	No. KP Baru
Policy No.	Old NRIC/BC/Passport No.
No. Polisi	No. KP Lama/Sijil Kelahiran/ Paspot
Policy No.	Name of Patient
No. Polisi	Nama Pesakit

1.	If treatment was a result from an accident, please provide details of accident. <i>Jika rawatan akibat kemalangan, sila kemukakan butiran berikut.</i> Date of Accident <i>Tarikh kejadian kemalangan</i> Time <i>Masa</i> AM/PM <i>Pagi/Petang</i> Nature of Accident <i>Jenis Kemalangan</i>
2.	Hospitalisation Detail <i>Butiran Masuk ke Hospital</i> Admission No. <i>Nombor Pendaftaran</i> Date of Admission/Day Surgery <i>Tarikh Kemasukan Hospital/Pembedahan Harian</i> Time <i>Masa</i> AM/PM <i>Pagi/Petang</i> Date of Discharge <i>Tarikh Discaj</i> Time <i>Masa</i> AM/PM <i>Pagi/Petang</i>
3.	What were the symptoms the patient complained when he/she first saw you? <i>Apakah simptom yang diberitahu oleh pesakit ketika pertama kali dia berjumpa dengan anda?</i>
4.	The date on which you first saw the patient for this condition. <i>Sila nyatakan tarikh pertama kali anda memberi rawatan kepada pesakit bagi keadaan ini.</i> Date <i>Tarikh</i>
5.	(a) According to the patient, how long had the patient been having these symptoms prior to the initial consultation with you? <i>Berdasarkan maklumat yang diberi oleh pesakit, berapa lamakah dia telah mengalami simptom ini sebelum kali pertama menemui anda?</i> (b) Based on your professional opinion, how long had the patient been having these symptoms prior to the initial consultation with you? <i>Pada pandangan anda, berapa lamakah dia telah mengalami simptom ini sebelum kali pertama menemui anda?</i>
6.	Had the patient previously received any medical consult for the above symptom(s)? If yes, please indicate the doctor's name, address, date of consultation and provide a copy of referral letter (if any). <i>Pernahkah pesakit menerima perundingan perubatan untuk simptom diatas? Jika ya, sila nyatakan nama, alamat doktor tersebut, tarikh rawatan serta berikan salinan surat rujukan (jika ada).</i> ☐ Yes <i>Ya</i> ☐ No <i>Tidak</i> Name <i>Nama</i> Address <i>Alamat</i> Date <i>Tarikh</i>
7.	Have any investigation, test or procedure been performed? If yes, please furnish us the detail or provide a certified true copy of result. <i>Adakah sebarang siasatan, ujian atau prosedur dilakukan? Jika ya, sila nyatakan maklumat lanjut atau lampirkan satu salinan siasatan yang disahkan daripada dokumen asal.</i> ☐ Yes <i>Ya</i> ☐ No <i>Tidak</i>
8.	What was the diagnosis? <i>Apakah diagnosis anda?</i>
9.	What is the underlying cause(s)/pathology/mechanism of injury for the above diagnosis? Please indicate the doctor's name, address and date of consultation (if any). <i>Apakah punca penyebab/patologi/mekanisme kecederaan bagi penyakit diatas? Sila nyatakan nama, alamat doktor tersebut dan tarikh rawatan (jika ada).</i>
10.	Did you inform the patient of the diagnosis? If yes, when? <i>Adakah anda memberitahu pesakit tentang diagnosis tersebut? Jika ya, bila?</i> ☐ Yes <i>Ya</i> ☐ No <i>Tidak</i> Date <i>Tarikh</i>

HSD-HSAPS-V02-082025a

11.	Nature of medical treatment given/planned and/or surgery to be performed. <i>Apakah jenis rawatan perubatan yang diberi/dirancang dan/atau pembedahan yang akan dijalankan.</i>	
12.	For surgery/procedure: <i>Untuk pembedahan/prosedur:</i> (a) Indication and Nature of surgery/procedure performed <i>Petunjuk dan Jenis pembedahan/prosedur</i> (b) Name of surgeon(s) <i>Nama pakar bedah</i> (c) MMA OPCS code/PHFSR code <i>Kod MMA OPCS/Kod PHFSR</i> (d) Date(s) of surgery/procedure performed <i>Tarikh pembedahan/prosedur dilakukan</i>	
13.	Has the patient previously been treated (outpatient) or hospitalised for this or any other disease? If yes, please furnish the details. <i>Pernahkah pesakit diberi rawatan secara pesakit luar atau dimasukkan ke hospital untuk rawatan penyakit ini atau penyakit-penyakit lain? Sila berikan maklumat lanjut.</i>	☐ Yes <i>Ya</i> ☐ No <i>Tidak</i> Date <i>Tarikh</i> Illness <i>Penyakit</i> Details of Treatment <i>Butir Rawatan</i> Hospital/Clinic <i>Hospital/Klinik</i> Address <i>Alamat</i>
14.	Was the illness/condition caused directly or indirectly by the following condition. If yes, please tick. <i>Adakah penyakit ini secara langsung atau tidak langsung berkaitan dengan keadaan berikut. Jika ya, sila tanda.</i> ☐ Pregnancy/Childbirth/Caeserean section/Miscarriage/Prenatal/Postnatal/Sterilization/Infertility. (If pregnancy related, gestation period _____ weeks). <i>Kehamilan/Kelahiran/Kelahiran secara Pembedahan/Keguguran/Sebelum Kelahiran Anak/Selepas Kelahiran Anak/Pensterilan/Kemandulan. (Jika berkaitan dengan Kehamilan, tempoh kehamilan _____ minggu).</i> ☐ Drug abuse/Intoxication <i>Penyalahgunaan Dadah/Kemabukan</i> ☐ Nervous/Mental/Emotional/Sleeping Disorder /Alternative Therapy <i>Penyakit Mental/Penyakit Gangguan Tidur/Alternatif Terapi</i> ☐ Cosmetic surgery/Dental care/Refractive errors connection <i>Pembedahan Kosmetik/Rawatan Pergigian/Pembetulan Penglihatan melalui Pembiasan</i> ☐ AIDS/HIV/STD/VD <i>AIDS/HIV/STD/VD</i> ☐ Self-inflicted injuries/Suicide/Attempted Suicide <i>Tindakan Melukakan Diri Sendiri/Bunuh Diri/Percubaan Bunuh Diri</i> ☐ Strike/Riot/Insurrection <i>Mogok/Rusuhan/Pemberontakan</i> ☐ None of the above <i>Semua diatas tidak berkenaan</i>	
Declaration "I hereby certify that the information above are full, complete and true as per record from the hospital/clinic." <i>"Saya dengan ini mengesahkan bahawa maklumat di atas adalah lengkap dan benar mengikut rekod hospital/klinik."</i>		
Signature and Stamp of Attending Physician/Surgeon <i>Tandatangan dan Cop Pengawai Perubatan/Pakar Bedah</i> Name of Physician/Surgeon _____ <i>Nama Doktor/Pakar bedah</i> Qualification <i>Kelayakan</i> _____ Contact No. <i>No. Tel</i> _____ Fax No. <i>No. Faks</i> _____ Date <i>Tarikh</i> _____ Hospital/Clinic _____ <i>Hospital/Klinik</i> Address <i>Alamat</i> _____ _____ _____ _____		