


LAPORAN PERUBATAN MENGENAI PESAKIT UNTUK PENGELUARAN KESIHATAN KWSP

Laporan perubatan ini disediakan oleh doktor yang merawat pesakit untuk menentukan tahap kesihatan pesakit bagi pihak KWSP. Laporan ini diperlukan bagi memenuhi syarat di bawah Skim Pengeluaran Kesihatan KWSP.

(Diisi oleh doktor yang merawat pesakit menggunakan pen dakwat hitam atau tulisan bertaip)

1.	NAMA PESAKIT <i>PATIENT'S NAME</i>							
2.	NO. PENDAFTARAN PESAKIT <i>PATIENT'S REGISTRATION NO.</i>							
3.	TARIKH MASUK HOSPITAL (Jika ada) <i>DATE OF ADMISSION (IF ANY)</i>							
4.	TARIKH KELUAR HOSPITAL (Jika ada) <i>DATE OF DISCHARGE (IF ANY)</i>							
5.	TARIKH KEMATIAN (Jika ada) <i>DATE OF DEATH (IF ANY)</i>							
6.	NO. KP 12 DIGIT / NO. SURAT BERANAK/NO. PASPORT <i>12 DIGIT NRIC NO. / BIRTH CERTIFICATE NO./ PASSPORT NO.</i>							
7.	UMUR / JANTINA <i>AGE / SEX</i>	<input type="checkbox"/> LELAKI / MALE <input type="checkbox"/> PEREMPUAN / FEMALE						
8.	PENYAKIT YANG DIHADAPI / ILLNESS Sila tandakan (v) pada ruangan yang disediakan / <i>Please indicate (v) below</i>							
	<table border="1"> <thead> <tr> <th>KATEGORI/JENIS PENYAKIT KRITIKAL</th> <th>KATEGORI/JENIS PENYAKIT KRITIKAL</th> </tr> </thead> <tbody> <tr> <td> CANCER <input type="checkbox"/> Cancer </td> <td> CARDIOVASCULAR SYSTEM <input type="checkbox"/> Arrhythmia Requiring Device Insertion (Pacemaker/ Defibrillator) <input type="checkbox"/> Cardiomyopathy/Heart Failure <input type="checkbox"/> Congenital Heart Disease <input type="checkbox"/> Constrictive Pericarditis <input type="checkbox"/> Coronary Artery Disease/Ischaemic Heart Disease <input type="checkbox"/> Heart Attack / Myocardial Infarction <input type="checkbox"/> Heart Block Requiring Surgical Intervention/Pacemaker/ Battery Implant <input type="checkbox"/> Heart Valve Replacement / Valvular Heart Disease Requiring Replacement <input type="checkbox"/> Peripheral Vascular Disease / Chronic Limb Threatening Ischaemia <input type="checkbox"/> Surgery to Aorta / Diseases of the Aorta Requiring Surgery <input type="checkbox"/> Rheumatic Heart Disease <input type="checkbox"/> Ruptured Sinus Valsalva <input type="checkbox"/> Chronic Symptomatic Venous Insufficiency </td> </tr> <tr> <td> ENDOCRINE/MEDICAL <input type="checkbox"/> Epilepsy & Movement Disorders Requiring Deep Brain Stimulation Or Surgery <input type="checkbox"/> Guillain Barre Syndrome Requiring Immunoglobulin Treatment <input type="checkbox"/> Morbid Obesity Or Obesity With Multiple Medical Complications And Life Threatening Requiring Bariatric Surgery: i. Morbid Obesity Without Any Comorbidities With BMI ≥ 37.5 kg/m² Who Fulfil The Selection Criteria Or ii. Morbid Obesity With Metabolic Syndrome With BMI ≥ 32.5 kg/m² With Metabolic Syndrome Or CV Risk Following Inadequate Weight Loss By Virtue Of Medical Therapy And Lifestyle Modifications. Please state patient's BMI: <input type="checkbox"/> Pituitary Tumors <input type="checkbox"/> Sepsis With One Or More Major Organ Failure <input type="checkbox"/> Type 1 Diabetes With Criteria For Insulin Pump Therapy <input type="checkbox"/> Diabetic Ketoacidosis <input type="checkbox"/> Adrenal Crisis /Addisonian Crisis <input type="checkbox"/> Thyroid Storm / Hashimoto Thyroid Disease / Graves' Disease </td> <td></td> </tr> </tbody> </table>	KATEGORI/JENIS PENYAKIT KRITIKAL	KATEGORI/JENIS PENYAKIT KRITIKAL	CANCER <input type="checkbox"/> Cancer	CARDIOVASCULAR SYSTEM <input type="checkbox"/> Arrhythmia Requiring Device Insertion (Pacemaker/ Defibrillator) <input type="checkbox"/> Cardiomyopathy/Heart Failure <input type="checkbox"/> Congenital Heart Disease <input type="checkbox"/> Constrictive Pericarditis <input type="checkbox"/> Coronary Artery Disease/Ischaemic Heart Disease <input type="checkbox"/> Heart Attack / Myocardial Infarction <input type="checkbox"/> Heart Block Requiring Surgical Intervention/Pacemaker/ Battery Implant <input type="checkbox"/> Heart Valve Replacement / Valvular Heart Disease Requiring Replacement <input type="checkbox"/> Peripheral Vascular Disease / Chronic Limb Threatening Ischaemia <input type="checkbox"/> Surgery to Aorta / Diseases of the Aorta Requiring Surgery <input type="checkbox"/> Rheumatic Heart Disease <input type="checkbox"/> Ruptured Sinus Valsalva <input type="checkbox"/> Chronic Symptomatic Venous Insufficiency	ENDOCRINE/MEDICAL <input type="checkbox"/> Epilepsy & Movement Disorders Requiring Deep Brain Stimulation Or Surgery <input type="checkbox"/> Guillain Barre Syndrome Requiring Immunoglobulin Treatment <input type="checkbox"/> Morbid Obesity Or Obesity With Multiple Medical Complications And Life Threatening Requiring Bariatric Surgery: i. Morbid Obesity Without Any Comorbidities With BMI ≥ 37.5 kg/m ² Who Fulfil The Selection Criteria Or ii. Morbid Obesity With Metabolic Syndrome With BMI ≥ 32.5 kg/m ² With Metabolic Syndrome Or CV Risk Following Inadequate Weight Loss By Virtue Of Medical Therapy And Lifestyle Modifications. Please state patient's BMI: <input type="checkbox"/> Pituitary Tumors <input type="checkbox"/> Sepsis With One Or More Major Organ Failure <input type="checkbox"/> Type 1 Diabetes With Criteria For Insulin Pump Therapy <input type="checkbox"/> Diabetic Ketoacidosis <input type="checkbox"/> Adrenal Crisis /Addisonian Crisis <input type="checkbox"/> Thyroid Storm / Hashimoto Thyroid Disease / Graves' Disease		
KATEGORI/JENIS PENYAKIT KRITIKAL	KATEGORI/JENIS PENYAKIT KRITIKAL							
CANCER <input type="checkbox"/> Cancer	CARDIOVASCULAR SYSTEM <input type="checkbox"/> Arrhythmia Requiring Device Insertion (Pacemaker/ Defibrillator) <input type="checkbox"/> Cardiomyopathy/Heart Failure <input type="checkbox"/> Congenital Heart Disease <input type="checkbox"/> Constrictive Pericarditis <input type="checkbox"/> Coronary Artery Disease/Ischaemic Heart Disease <input type="checkbox"/> Heart Attack / Myocardial Infarction <input type="checkbox"/> Heart Block Requiring Surgical Intervention/Pacemaker/ Battery Implant <input type="checkbox"/> Heart Valve Replacement / Valvular Heart Disease Requiring Replacement <input type="checkbox"/> Peripheral Vascular Disease / Chronic Limb Threatening Ischaemia <input type="checkbox"/> Surgery to Aorta / Diseases of the Aorta Requiring Surgery <input type="checkbox"/> Rheumatic Heart Disease <input type="checkbox"/> Ruptured Sinus Valsalva <input type="checkbox"/> Chronic Symptomatic Venous Insufficiency							
ENDOCRINE/MEDICAL <input type="checkbox"/> Epilepsy & Movement Disorders Requiring Deep Brain Stimulation Or Surgery <input type="checkbox"/> Guillain Barre Syndrome Requiring Immunoglobulin Treatment <input type="checkbox"/> Morbid Obesity Or Obesity With Multiple Medical Complications And Life Threatening Requiring Bariatric Surgery: i. Morbid Obesity Without Any Comorbidities With BMI ≥ 37.5 kg/m ² Who Fulfil The Selection Criteria Or ii. Morbid Obesity With Metabolic Syndrome With BMI ≥ 32.5 kg/m ² With Metabolic Syndrome Or CV Risk Following Inadequate Weight Loss By Virtue Of Medical Therapy And Lifestyle Modifications. Please state patient's BMI: <input type="checkbox"/> Pituitary Tumors <input type="checkbox"/> Sepsis With One Or More Major Organ Failure <input type="checkbox"/> Type 1 Diabetes With Criteria For Insulin Pump Therapy <input type="checkbox"/> Diabetic Ketoacidosis <input type="checkbox"/> Adrenal Crisis /Addisonian Crisis <input type="checkbox"/> Thyroid Storm / Hashimoto Thyroid Disease / Graves' Disease								

GASTROENTEROLOGY / HEPATOLOGY	GENITOURINARY SYSTEM
<input type="checkbox"/> Chronic Inflammatory Bowel Disease <input type="checkbox"/> Chronic Liver Disease <input type="checkbox"/> Fulminant Viral Hepatitis <input type="checkbox"/> Pulmonary Hypertension <input type="checkbox"/> Bowel Obstruction/ Perforation Requiring Surgery <input type="checkbox"/> Acute Pancreatitis Requiring Surgery <input type="checkbox"/> Gastrointestinal (GIT) Bleeding Requiring Surgery <input type="checkbox"/> Acute Appendicitis Requiring Surgery <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Celiac Disease <input type="checkbox"/> Biliary Stone Diseases Requiring Surgery <input type="checkbox"/> Strangulated Hernia Requiring Surgery <input type="checkbox"/> Severe Gastroesophageal Reflux Disease Requiring Surgery <input type="checkbox"/> Esophageal Functional Disorder with Manometry Evidence	<input type="checkbox"/> Congenital Urinary Abnormalities Requiring Urgent And Major Surgical Intervention <input type="checkbox"/> Chronic Kidney Disease/Failure <input type="checkbox"/> Medullary Cystic Disease <input type="checkbox"/> Renal Calculi Requiring Surgical Intervention <input type="checkbox"/> Interstitial Cystitis Requiring Intravesical Device <input type="checkbox"/> Testicular Torsion Requiring Surgery <input type="checkbox"/> Abnormal Uterine Bleeding Requiring Surgery <input type="checkbox"/> Uterine Fibroid Requiring Surgery <input type="checkbox"/> Endometriosis Severe Or Requiring Surgery
HEMATOLOGY	ILLNESS OF CHILD UNDER 16 YEARS OLD
<input type="checkbox"/> Aplastic Anaemia <input type="checkbox"/> Haemophilia (Moderate To Severe - Factor Activity <5%) / Acquired Haemophilia <input type="checkbox"/> Hematological Malignancies – Leukemia, Multiple Myeloma (Acute Or Chronic Leukemia Diagnosed By Physician) <input type="checkbox"/> Hematopoetic Stem Cell Transplantation <input type="checkbox"/> Idiopathic Thrombocytopenic Purpura (ITP) – Thrombocytopenia Refractory To Convention Steroid Treatment (1st Line Treatment) <input type="checkbox"/> Lymphoma <input type="checkbox"/> Myeloproliferative Disorders Requiring Blood Transfusion And/Or Chelating Agents <input type="checkbox"/> Thalassaemia Major Requiring Chelating Agent <input type="checkbox"/> Thrombophilia Disease With Targeted Organ Complications <input type="checkbox"/> Graft Vs Host Disease <input type="checkbox"/> Myelofibrosis	<input type="checkbox"/> Congenital Diseases Requiring Medical Or Surgical Intervention Treated By Specialist <input type="checkbox"/> Intellectual Impairment Due To Accident Or Sickness <input type="checkbox"/> Leukaemia <input type="checkbox"/> Severe Asthma
MENTAL AND NEURODEVELOPMENTAL DISORDER	MUSCULOSKELETAL SYSTEM
<input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Major Depression <input type="checkbox"/> Schizophrenia Or Other Primary Psychotic Disorders <input type="checkbox"/> Attention Deficit Hyperactivity Disorder (Moderate to Severe Up to 18 Years Old) <input type="checkbox"/> Intellectual Disability (Moderate to Severe Up to 18 Years Old) <input type="checkbox"/> Autism Spectrum Disorder (Moderate to Severe Up to 18 Years Old)	<input type="checkbox"/> Systemic Lupus Erythematosus (SLE) With Major Organ Involvement <input type="checkbox"/> Systemic Sclerosis/Scleroderma with Functional Impairment And/Or Major Organ Involvement <input type="checkbox"/> Chronic Or Large Diabetic Foot Ulcer Requiring Amputation Or Vacuum Dressing. <input type="checkbox"/> Congenital Hand Deformity Requiring Surgery with Or Without Prothesis /Orthosis
NERVOUS SYSTEM	OPHTHALMOLOGY <i>(Sila juga penuhkan Ruangan 9/Please also complete paragraph 9)</i>
<input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Appalic Syndrome <input type="checkbox"/> Benign Tumor Of Brain <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Coma <input type="checkbox"/> Encephalitis <input type="checkbox"/> Loss Of Speech <input type="checkbox"/> Major Head Trauma <input type="checkbox"/> Meningitis <input type="checkbox"/> Motor Neuron Disease <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Paralysis <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Poliomyelitis <input type="checkbox"/> Stroke <input type="checkbox"/> Total Permanent Disability <input type="checkbox"/> Brain Abscess <input type="checkbox"/> Myasthenia Gravis	<input type="checkbox"/> Advanced Diabetic Eye Disease - Diagnose By Specialist <input type="checkbox"/> Age Related Macular Degeneration (Armd)/Polypoidal Choroidal Vasculopathy (PCV) <input type="checkbox"/> Blindness <input type="checkbox"/> Cataract Requiring Surgery (Intraocular Lens – IOL) <input type="checkbox"/> Corneal Disorders Requiring Corneal Surgery (Corneal Transplant) – Diagnose By Specialist <input type="checkbox"/> Enophthalmic Socket - Diagnose By Specialist <input type="checkbox"/> Glaucoma Requiring Surgery With Glaucoma Implant <input type="checkbox"/> Retinal Vascular Disease - Diagnose By Specialist <input type="checkbox"/> Corneal Ulcer / Endophthalmitis Requiring Surgery <input type="checkbox"/> Diabetic Macular Edema Requiring Anti-VEGF Injections <input type="checkbox"/> Paediatric Squint Requiring Surgery For Less Than 12 Years Old Patient (To Prevent Amblyopia) Excluding Aesthetics Condition. <input type="checkbox"/> Retinal Disease Requiring Surgery

ORTHOPEDIC		RESPIRATORY SYSTEM	
<input type="checkbox"/>	Gangrene / Necrotizing Fasciitis Requiring Surgery	<input type="checkbox"/>	Bronchiectasis
<input type="checkbox"/>	Knee / Hip/ Ankle / Foot Injury Requiring Surgery (Implant/Graft) Or Prosthesis / Orthosis	<input type="checkbox"/>	Chronic Lung Disease
<input type="checkbox"/>	Osteoarthritis of knee /hip requiring Surgery/Implant/ Sodium Hyaluronate Injection At Least 12 Weeks For Grade I - Grade II And 6 Weeks For Grade III After Undergoing Conservative Treatment. (Maximum 2 Injections - Single Injections Per Joints Per Sessions)	<input type="checkbox"/>	Interstitial Lung Disease
<input type="checkbox"/>	Prolapse Intervertebral Disc With Significant Neurological Deficit Requiring Surgery	<input type="checkbox"/>	Obstructive Sleep Apnoea
<input type="checkbox"/>	Shoulder Injury With Instability/Function Compromised Requiring Surgery/Implant/Graft	<input type="checkbox"/>	Secondary Pulmonary Hypertension
<input type="checkbox"/>	Spinal Stenosis With Significant Neurological Symptoms/Deficit Requiring Surgery	<input type="checkbox"/>	Severe Chronic Obstructive Pulmonary Disease (COPD)
<input type="checkbox"/>	Unstable Spine Fractures / Trauma Requiring Surgery And Implant/Rehab Equipment	<input type="checkbox"/>	Tuberculosis
		<input type="checkbox"/>	Pneumonia That Needs Hospitalisation
		<input type="checkbox"/>	Lung Empyema
		<input type="checkbox"/>	Pulmonary Embolism
RHEUMATOLOGY		SKIN DISEASE (NOT RESPONDING TO CONVENTIONAL TREATMENT)	
<input type="checkbox"/>	Ankylosing Spondyloarthritis Active Disease With Functional Impairment And/Or Disability	<input type="checkbox"/>	Severe Atopic Dermatitis
<input type="checkbox"/>	Chronic Tophaceous Gout With Functional Impairment And/Or Disability.	<input type="checkbox"/>	Severe Autoimmune Blistering Disorders
<input type="checkbox"/>	Psoriatic Arthritis Active Disease With Functional Impairment And/Or Disability	<input type="checkbox"/>	Severe Dermatomyositis And Polymyositis
<input type="checkbox"/>	Rheumatoid Arthritis / Arthritis Of Any Joint With Deformities Requiring Surgery/Orthosis	<input type="checkbox"/>	Severe Hidradenitis Suppurativa
		<input type="checkbox"/>	Complicated Steven Johnson Syndrome/ Toxic Epidermal Necrolysis
		<input type="checkbox"/>	Epidermolysis Bullosa (Hereditary)
		<input type="checkbox"/>	Psoriatic Arthritis
		<input type="checkbox"/>	Severe Chronic Spontaneous Urticaria
		<input type="checkbox"/>	Severe Psoriasis / Generalised Pustular Psoriasis
		<input type="checkbox"/>	Chronic Eczema
OTHER DISEASES APPROVED BY EPF BOARD			
<input type="checkbox"/>	AIDS (Accompanied with AIDS defining disease) / HIV (Second Line Treatment)	<input type="checkbox"/>	Terminal Illness
<input type="checkbox"/>	Deafness	<input type="checkbox"/>	Facial Bone Fractures Requiring Surgery
<input type="checkbox"/>	Loss Of Independent Existence	<input type="checkbox"/>	Craniofacial Anomalies Less Than 18 Years Old And Requiring Surgery
<input type="checkbox"/>	Major Burns	<input type="checkbox"/>	Multiple Resistant Staphylococcus Aureus / Extended-Spectrum Beta-Lactamase (ESBL)
<input type="checkbox"/>	Major Organ Transplant		
9.	<p>BAHAGIAN INI HANYA PERLU DIISI BAGI PENYAKIT YANG MELIBATKAN OFTALMOLOGI. SILA TERUSKAN KE BAHAGIAN 10 SEKIRANYA MELIBATKAN LAIN-LAIN PENYAKIT.</p> <p><i>THIS SECTION IS ONLY REQUIRED TO BE COMPLETED FOR AN OPHTHALMOLOGY RELATED DISEASE. PLEASE PROCEED TO SECTION 10 FOR OTHER ILLNESSES.</i></p>	<p>Tahap penglihatan selepas pembetulan dengan cermin mata/kanta sentuh: <i>Vision level after correction with glasses/contact lens</i> Mata kanan (<i>Right eye</i>): Mata kiri (<i>Left eye</i>):</p> <p>Medan penglihatan: <i>Visual field</i> Mata kanan (<i>Right eye</i>): Mata kiri (<i>Left eye</i>):</p> <p>Lain-lain hasil penyiasatan yang berkaitan: <i>Other related investigation results</i> (i) Optical coherent tomography (OCT): (ii) <i>Fundus angiography</i>:</p> <p>Sila tandakan (v) pada petak yang berkaitan: <i>Please indicate (v) in the relevant box</i></p> <p><input type="checkbox"/> Terhad di kedua-dua belah mata (penglihatan lebih teruk dari 6/18 tetapi sama atau lebih baik daripada 3/60 ATAU medan penglihatan kurang dari 20 darjah dari fixation). <i>Limited in both eyes (vision is worse than 6/18 but equal to or better than 3/60 OR visual field is less than 20 degrees from the point of fixation).</i></p> <p><input type="checkbox"/> Buta kedua-dua belah mata (penglihatan kurang daripada 3/60 ATAU medan penglihatan kurang daripada 10 darjah dari fixation). <i>Blindness of both eyes (vision is less than 3/60 OR visual field is less than 10 degrees from the point of fixation).</i></p> <p><input type="checkbox"/> Buta di sebelah mata. <i>Blind in one eye</i></p>	

10.	KETERANGAN LANJUT TENTANG PENYAKIT <i>DETAILED INFORMATION ABOUT THE ILLNESS</i>	
11.	SILA NYATAKAN IMPLIKASI PENYAKIT TERSEBUT JIKA TIDAK DIRAWAT DENGAN SEGERA <i>PLEASE STATE THE IMPLICATION IF THE ILLNESS IS NOT TREATED IMMEDIATELY</i>	
12.	KATEGORI PENYAKIT <i>DISEASE CATEGORY</i>	i. Kritikal / Critical <input type="checkbox"/> Tidak Kritikal / Not Critical <input type="checkbox"/> ii. Kronik / Chronic <input type="checkbox"/> Tidak Kronik / Not Chronic <input type="checkbox"/> iii. Lain-Lain (Sila Nyatakan) / Others (Please Specify) :
13.	LAIN-LAIN PENYAKIT YANG DIHADAPI <i>OTHER ILLNESS</i>	
14.	KAEDAH RAWATAN <i>TYPE OF TREATMENT</i>	
15.	PERALATAN BANTUAN KESIHATAN <i>MEDICAL SUPPORT EQUIPMENT/PERIPHERALS REQUIRED</i>	Adakah kaedah rawatan memerlukan peralatan bantuan kesihatan ? <i>Is the type of treatment requires any medical support equipment and peripherals ?</i> YA / YES <input type="checkbox"/> TIDAK / NO <input type="checkbox"/> Jika 'Ya', sila nyatakan / If 'Yes' please state :
16.	PEMBEDAHAN (Jika ada) <i>SURGERY (IF ANY)</i>	
17.	KOS ANGGARAN RAWATAN / PERALATAN BANTUAN KESIHATAN <i>ESTIMATED TREATMENT / MEDICAL SUPPORT EQUIPMENT AND PERIPHERALS COST</i> *Hanya dilengkapkan bagi pesakit yang ingin mendapatkan rawatan di luar negara	Kos Anggaran Rawatan : RM <i>Estimated Treatment Cost</i> Kos Anggaran Peralatan Bantuan Kesihatan : RM <i>Estimated Medical Support Equipment and Peripherals Cost</i>

*LAPORAN PERUBATAN YANG DISEDIAKAN OLEH DOKTOR HOSPITAL KERAJAAN PERLU MELALUI UNIT REKOD HOSPITAL / MEDICAL REPORT PREPARED BY DOCTOR'S FROM GOVERNMENT HOSPITALS ARE REQUIRED TO BE PROCESSED THROUGH UNIT REKOD HOSPITAL.

SAYA SAHKAN MAKLUMAT YANG DIBERIKAN DIATAS ADALAH BENAR

I CERTIFIED THAT THE INFORMATION GIVEN ABOVE IS TRUE

.....
TANDATANGAN & NAMA DOKTOR, NO. MPM
DAN CAP RASMI HOSPITAL / KLINIK
 SIGNATURE & DOCTOR'S NAME
 AND HOSPITAL/CLINIC OFFICIAL STAMP

TARIKH :
 DATE