

Certificate No. <i>No. Sijil</i>	<input type="text"/>	New NRIC No. <i>No. KP Baru</i>	<input type="text"/> - <input type="text"/> - <input type="text"/>
Certificate No. <i>No. Sijil</i>	<input type="text"/>	Old NRIC/BC/Passport No. <i>No. KP Lama/Sijil Kelahiran /Paspot</i>	<input type="text"/>
Certificate No. <i>No. Sijil</i>	<input type="text"/>	Name of Patient <i>Nama Pesakit</i>	<input type="text"/>

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>	<input type="checkbox"/> Yes <i>Ya</i> <input type="checkbox"/> 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>	<input type="checkbox"/> Yes <i>Ya</i> <input type="checkbox"/> 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>	<input type="checkbox"/> Yes <i>Ya</i> <input type="checkbox"/> No <i>Tidak</i> Date <i>Tarikh</i>

CLM-HSAPS-V06-052022-TAKAFUL

