KUMPULAN WANG SIMPANAN PEKERJA

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.

1.	NAMA PESAKIT *PATIENT'S NAME*	
2.	NO. PENDAFTARAN PESAKIT *PATIENT'S REGISTRATION NO.*	
3.	TARIKH MASUK HOSPITAL (Jika ada) *DATE OF ADMISSION (If any)*	
4.	TARIKH KELUAR HOSPITAL (Jika ada) *DATE OF DISCHARGE (If any)*	
5.	TARIKH KEMATIAN (Jika ada) *DATE OF DEATH (If any)*	
6.	NO. KP 12 DIGIT / NO. SURAT BERANAK/NO. PASPORT *12 DIGIT NRIC NO. / BIRTH CERTIFIICATE NO./PASSPORT NO.*	
7.	UMUR / JANTINA *AGE / GENDER*	☐ LELAKI / *MALE* ☐ PEREMPUAN / *FEMALE* ☐

8. PENYAKIT YANG DIHIDAPI / *ILLNESS*

Sila tandakan (x) pada ruangan yang disediakan / *Please indicate (x) below*

KATEGORI/JENIS PENYAKIT KRITIKAL	**KATEGORI/JENIS PENYAKIT KRITIKAL**
CANCER	**NERVOUS SYSTEM**
☐ Cancer	☐ Alzheimer's Disease ☐ Appalic Syndrome ☐ Benign Tumor Of Brain ☐ Cerebral Palsy ☐ Coma ☐ Encephalitis ☐ Loss Of Speech ☐ Major Head Trauma ☐ Meningitis ☐ Motor Neurone Disease ☐ Multiple Sclerosis ☐ Muscular Dystrophy ☐ Paralysis ☐ Parkinson's Disease ☐ Poliomyelitis ☐ Stroke ☐ Total Permanent Disability
CARDIOVASCULAR SYSTEM ☐ Arrhythmia Requiring Device Insertion (Pacemaker/Defibrillator) ☐ Cardiomyopathy/Heart Failure ☐ Congenital Heart Disease ☐ Constrictive Pericarditis ☐ Coronary Artery Disease/Ischaemic Heart Disease ☐ Heart Attack / Myocardial Infarction ☐ Heart Block Requiring Surgical Intervention/Pacemaker/Battery Implant ☐ Heart Valve Replacement / Valvular Heart Disease Requiring Replacement ☐ Peripheral Vascular Disease ☐ Surgery to Aorta / Diseases of the Aorta Requiring Surgery	
ENDOCRINE/MEDICAL	**OPHTHALMOLOGY** ***(Sila penuhkan juga Ruangan 9/Please also complete paragraph 9)***
☐ Epilepsy & Movement Disorders Requiring Deep Brain Stimulation Or Surgery ☐ Guillain Barre Syndrome Requiring Immunoglobulin Treatment ☐ Morbid Obesity Or Obesity With Multiple Medical Complications And Life Threatening Requiring Bariatric Surgery ☐ Pituitary Tumors ☐ Sepsis With One Or More Major Organ Failure ☐ Type 1 Diabetes With Criteria For Insulin Pump Therapy	☐ Advanced Diabetic Eye Disease - Diagnose By Specialist ☐ Age Related Macular Degeneration (Armd)/Polypoidal Choroidal Vasculopathy (PCV) ☐ Blindness ☐ Cataract Requiring Surgery (Intraocular Lens – IOL) ☐ Corneal Disorders Requiring Corneal Surgery (Corneal Transplant) – Diagnose By Specialist ☐ Enopthalmic Socket - Diagnose By Specialist ☐ Glaucoma Requiring Surgery With Glaucoma Implant ☐ Retinal Vascular Disease - Diagnose By Specialist

GASTROENTEROLOGY / HEPATOLOGY	ORTHOPEDIC
☐ Chronic Inflammatory Bowel Disease ☐ Chronic Liver Disease ☐ Fulminant Viral Hepatitis ☐ Pulmonary Hypertension	☐ Gangrene / Necrotizing Fasciitis Requiring Amputation ☐ Knee Injury Requiring Surgery/Implant/Graft ☐ Osteoarthritis Requiring Surgery/Implant ☐ Prolapse Intervertebral Disc With Significant Neurological Deficit Requiring Surgery ☐ Shoulder Injury With Instability/Function Compromised Requiring Surgery/Implant/Graft ☐ Spinal Stenosis With Significant Neurological Symptoms/Deficit Requiring Surgery ☐ Unstable Spine Fractures / Trauma Requiring Surgery And Implant/ Rehab Equipment
GENITOURINARY SYSTEM	
☐ Congenital Urinary Abnormalities Requiring Urgent And Major Surgical Intervention ☐ Chronic Kidney Disease/Failure ☐ Medullary Cystic Disease ☐ Renal Calculi Requiring Surgical Intervention	
HEMATOLOGY	**RESPIRATORY SYSTEM**
☐ Aplastic Anaemia ☐ Haemophilia (Moderate To Severe - Factor Activity <5%) ☐ Hematological Malignancies – Leukemia, Multiple Myeloma (Acute Or Chronic Leukemia Diagnosed By Physician) ☐ Hematopoietic Stem Cell Transplantation ☐ Idiopathic Thrombocytopenic Purpura (ITP) - Thrombocytopenia Refractory To Convention Steroid Treatment (1st Line Treatment) ☐ Lymphoma ☐ Myeloproliferative Disorders Requiring Blood Transfusion And/Or Chelating Agents ☐ Thalassaemia Major Requiring Chelating Agent	☐ Bronchiectasis ☐ Chronic Lung Disease ☐ Lung Fibrosis ☐ Obstructive Sleep Apnoea ☐ Secondary Pulmonary Hypertension ☐ Severe Chronic Obstructive Pulmonary Disease (COPD) / Emphysema
ILLNESS OF CHILD UNDER 16 YEARS OLD	**RHEUMATOLOGY**
☐ Congenital Diseases Requiring Medical Or Surgical Intervention Treated By Specialist ☐ Intellectual Impairment Due To Accident Or Sickness ☐ Leukaemia ☐ Severe Asthma	☐ Ankylosing Spondyloarthritis Active Disease With Functional Impairment And/Or Disability ☐ Chronic Tophaceous Gout With Functional Impairment And/Or Disability. ☐ Psoriatic Arthritis Active Disease With Functional Impairment And /Or Disability ☐ Rheumatoid Arthritis / Arthritis Of Any Joint With Deformities Requiring Surgery/Orthosis
MENTAL ILLNESS	
☐ Bipolar Mood ☐ Major Depression ☐ Schizophrenia	
MUSCULOSKELETAL SYSTEM	**OTHER DISEASES APPROVED BY EPF BOARD**
☐ Systemic Lupus Erythematosus (SLE) With Major Organ Involvement ☐ Systemic Sclerosis/Scleroderma With Functional Impairment And/Or Major Organ Involvement	☐ AIDS (Accompanied with AIDS defining disease) / HIV (Second Line Treatment) ☐ Deafness ☐ Loss Of Independent Existence ☐ Major Burns ☐ Major Organ Transplant ☐ Terminal Illness

No.	Section	Details
9.	BAHAGIAN INI HANYA PERLU DIISI BAGI PENYAKIT YANG MELIBATKAN OFTALMOLOGI. SILA TERUSKAN KE BAHAGIAN 10 SEKIRANYA MELIBATKAN LAIN-LAIN PENYAKIT. *THIS SECTION IS ONLY REQUIRED TO BE COMPLETED FOR AN OPHTHALMOLOGY RELATED DISEASE. PLEASE PROCEED TO SECTION 10 FOR OTHER ILLNESSES.*	**Tahap penglihatan selepas pembetulan dengan cermin mata/kanta sentuh:** *Vision level after correction with glasses/contact lens* Mata kanan (*Right eye*): Mata kiri (*Left eye*): **Medan penglihatan:** *Visual field* Mata kanan (*Right eye*): Mata kiri (*Left eye*): **Lain-lain hasil penyiasatan yang berkaitan:** *Other related investigation results* (i) Optical coherent tomography (OCT): (ii) Fundus angiography:

		Sila tandakan (x) pada petak yang berkaitan: *Please indicate (x) in the relevant box* ☐ 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). *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).* ☐ Buta kedua-dua belah mata (penglihatan kurang daripada 3/60 ATAU medan penglihatan kurang daripada 10 darjah dari fixation). *Blindness of both eyes (vision is less than 3/60 OR visual field is less than 10 degrees from the point of fixation).* ☐ Buta di sebelah mata. *Blind in one eye*
10.	KETERANGAN LANJUT TENTANG PENYAKIT *DETAILED INFORMATION ABOUT THE ILLNESS*	
11.	SILA NYATAKAN IMPLIKASI PENYAKIT TERSEBUT JIKA TIDAK DIRAWAT DENGAN SEGERA *PLEASE STATE THE IMPLICATION IF THE ILLNESS IS NOT TREATED IMMEDIATELY*	
12.	PENYAKIT KRONIK / KRITIKAL *CHRONIC / CRITICAL ILLNESS*	YA / *YES* ☐ TIDAK / *NO* ☐
13.	LAIN-LAIN PENYAKIT YANG DIHIDAPI *OTHER ILLNESS*	
14.	KAEDAH RAWATAN *TYPE OF TREATMENT*	
15.	PERALATAN BANTUAN KESIHATAN *MEDICAL SUPPORT EQUIPTMENT/PERIPHERALS REQUIRED*	Adakah kaedah rawatan memerlukan peralatan bantuan kesihatan ? *Is the type of treatment requires any medical support equipment and peripherals ?* YA / *YES* ☐ TIDAK / *NO* ☐ Jika ' Ya', sila nyatakan / *If 'Yes' please state :*
16.	PEMBEDAHAN (Jika ada) *SURGERY (If any)*	
17.	KOS ANGGARAN RAWATAN / PERALATAN BANTUAN KESIHATAN *ESTIMATED TREATMENT / MEDICAL SUPPORT EQUIPMENT AND PERIPHERALS COST* ***Hanya dilengkapkan bagi pesakit yang ingin mendapatkan rawatan di luar negara***	Kos Anggaran Rawatan : RM *Estimated Treatment Cost* Kos Anggaran Peralatan Bantuan Kesihatan : RM *Estimated Medical Support Equipment and Peripherals Cost*

SAYA SAHKAN MAKLUMAT YANG DIBERIKAN DI ATAS ADALAH BENAR
I CERTIFIED THAT THE INFORMATION GIVEN ABOVE IS TRUE

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TANDATANGAN & NAMA DOKTOR, NO. MPM
DAN COP RASMI HOSPITAL
SIGNATURE & DOCTOR'S NAME
AND HOSPITAL OFFICIAL STAMP

TARIKH :
DATE