HOSPITALISATION & SURGICAL CLAIM - ATTENDING PHYSICIAN'S STATEMENT

BORANG TUNTUTAN RAWATAN HOSPITAL - KENYATAAN DOKTOR YANG MERAWAT

Great Eastern TAKAFUL

Certificate No. *No. Sijil* | New NRIC No. *No. KP Baru* | - -

Certificate No. *No. Sijil* | Old NRIC/BC/Passport No. *No. KP Lama/Sijil Kelahiran /Paspot*

Certificate No. *No. Sijil* | Name of Patient *Nama Pesakit*

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

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11.	Nature of medical treatment given/planned and/or surgery to be performed. *Apakah jenis rawatan perubatan yang diberi/dirancang dan/atau pembedahan yang akan dijalankan.*	
12.	For surgery/procedure: *Untuk pembedahan/prosedur:* (a) Indication and Nature of surgery/procedure performed *Petunjuk dan Jenis pembedahan/prosedur*	
	(b) Name of surgeon(s) *Nama pakar bedah*	
	(c) MMA OPCS code/PHFSR code *Kod MMA OPCS/Kod PHFSR*	
	(d) Date(s) of surgery/procedure performed *Tarikh pembedahan/prosedur dilakukan*	
13.	Has the patient previously been treated (outpatient) or hospitalised for this or any other disease? If yes, please furnish the details. *Pernahkah pesakit diberi rawatan secara pesakit luar atau dimasukkan ke hospital untuk rawatan penyakit ini atau penyakit-penyakit lain? Sila berikan maklumat lanjut.*	☐ Yes *Ya* ☐ No *Tidak* Date *Tarikh* Illness *Penyakit* Details of Treatment *Butir Rawatan* Hospital/Clinic *Hospital/Klinik* Address *Alamat*

14. Was the illness/condition caused directly or indirectly by the following condition. If yes, please tick.
Adakah penyakit ini secara langsung atau tidak langsung berkaitan dengan keadaan berikut. Jika ya, sila tanda.

- ☐ Pregnancy/Childbirth/Caeserean section/Miscarriage/Prenatal/Postnatal/Sterilization/Infertility.
  (If pregnancy related, gestation period _____ weeks).
  Kehamilan/Kelahiran/Kelahiran secara Pembedahan/Keguguran/Sebelum Kelahiran Anak/Selepas Kelahiran Anak/Pensterilan/ Kemandulan. (Jika berkaitan dengan Kehamilan, tempoh kehamilan_____minggu).
- ☐ Drug abuse/Intoxication
  Penyalahgunaan Dadah/Kemabukan
- ☐ Nervous/Mental/Emotional/Sleeping Disorder /Alternative Therapy
  Penyakit Mental/Penyakit Gangguan Tidur/Alternatif Terapi
- ☐ Cosmetic surgery/Dental care/Refractive errors connection
  Pembedahan Kosmetik/Rawatan Pergigian/Pembetulan Penglihatan melalui Pembiasan
- ☐ AIDS/HIV/STD/VD
  AIDS/HIV/STD/VD
- ☐ Self-inflicted injuries/Suicide/Attempted Suicide
  Tindakan Melukakan Diri Sendiri/Bunuh Diri/Percubaan Bunuh Diri
- ☐ Strike/Riot/Insurrection
  Mogok/Rusuhan/Pemberontakan
- ☐ None of the above
  Semua diatas tidak berkenaan

Declaration
"I hereby certify that the information above are full, complete and true as per record from the hospital/clinic."
"Saya dengan ini mengesahkan bahawa maklumat di atas adalah lengkap dan benar mengikut rekod hospital/klinik."

_____
Signature and Stamp of Attending Physician/Surgeon
Tandatangan dan Cop Pengawai Perubatan/Pakar Bedah

Name of Physician/Surgeon _____
Nama Doktor/Pakar bedah

Qualification *Kelayakan* _____

Contact No. *No. Tel* _____

Fax No. *No. Faks* _____

Date *Tarikh* _____

Hospital/Clinic _____
Hospital/Klinik

Address *Alamat* _____