



TAKAFUL IKHLAS FAMILY BERHAD Registration No. 200201025412 (593075-U)

IKHLAS Point, Tower 11A, Avenue 5, Bangsar South,

No. 8, Jalan Kerinchi, 59200 Kuala Lumpur

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LAPORAN PERUBATAN TUNTUTAN KELUARGA
FAMILY CLAIMS MEDICAL REPORT

Peringatan / Reminders

- 1 Borang ini hendaklah diisi oleh Pegawai Perubatan bertauliah yang memberi rawatan kepada pesakit berkenaan
This form must be completed by the certified Medical Officer who had treated the patient
- 2 Segala perbelanjaan untuk mendapatkan laporan ini adalah menjadi tanggungan pesakit.
Any cost incurred in relation to this report is to be borne by the patient.

NO. SIJIL / CERTIFICATE NO.

A. MAKLUMAT PERIBADI PESAKIT / PATIENT'S PERSONAL DETAILS

1 a. Nama Pesakit/ Name of Patient:

b. No. Kad Pengenalan: Baru: _____ Lama: _____

NRIC No.:

New: _____

Old: _____

d. Umur: _____

e. Jantina : ☐ Lelaki ☐ Perempuan

Male

Female

Age:

Sex :

B. BUTIR-BUTIR PERUBATAN / TREATMENT DETAILS

1 a. (i) Pemeriksaan kesakitan / kecederaan.

Diagnosis of illness / injury.

(ii) Nyatakan dengan terperinci penyakit yang dihidapi oleh peserta

Please explain in detail regarding the patient's illness.

b. (i) Tarikh pertama pesakit disahkan mendapat penyakit tersebut **(dd/mm/yyyy)**

First date where patient was diagnosed with the illness.

(ii) Tarikh pertama anda memberi rawatan. **(dd/mm/yyyy)**

Date you were first consulted.

c. (i) Berapa lamakah keadaan ini telah wujud? **(dd/mm/yyyy)**

How long has this condition existed? (dd/mm/yyyy)

(ii) Bila peserta mula mengetahui tentang penyakit ini? **(dd/mm/yyyy)**

When did the participant first aware of the disease? (dd/mm/yyyy)

(iii) Tarikh pertama simptom penyakit wujud? **(dd/mm/yyyy)**

First date symptoms of illness existed (dd/mm/yyyy).

d. (i) Tarikh pertama peserta dimasukkan ke hospital / menerima rawatan **(dd/mm/yyyy)**

First date that the patient was warded / received treatment.

(ii) Adakah peserta dirujuk dari klinik / hospital?

Jika Ya, sila nyatakan nama dan alamat klinik /

Was the patient referred from clinic / hospital?

If Yes, please state the clinic's / hospital's name and address.

Tarikh Rawatan Date	Penyakit Diagnosis	Nama Doktor dan Alamat Name and Address of Doctor

e. Jenis prosedur / rawatan yang telah diberi

Nature of procedure / treatment given

f. Tarikh prosedur / rawatan yang telah diberi

Nature of procedure / treatment given

<p>g. (iv) Adakah apa-apa dalam sejarah pesakit yang mungkin menyumbangkan secara langsung atau tidak langsung kepada penyakit ini? (dd/mm/yyyy) <i>Is there in the patient's history that relates directly or indirectly to this illness?</i></p> <p>(v) Adakah pesakit menghidapi penyakit-penyakit lain i.e. Diabetes, Mellitus, darah tinggi atau masalah jantung? Jika Ya, sila nyatakan sejak bila. (dd/mm/yyyy) <i>Does the patient suffered any other illness such as i.e. Diabetes mellitus, Hypertension or heart problem? If Yes, please state</i></p>	<p><i>* If 'YES', please state the illness and date of first diagnosed</i></p> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Ya Yes </div> <div> <input type="checkbox"/> Tidak No </div> <div> Nama penyakit / Kecederaan: <i>Illness / Injury :</i> </div> </div> <div style="border-bottom: 1px solid black; height: 15px; margin-top: 5px;"></div> <div style="text-align: right; margin-top: 10px;"> Tarikh disahkan: <i>Date 1st diagnosed:</i> </div> <div style="border-bottom: 1px solid black; height: 15px; margin-top: 5px;"></div> <p><i>* If 'YES', please state the illness and date of first diagnosed</i></p> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div>Hypertension</div> <div> <input type="checkbox"/> Ya Yes </div> <div> <input type="checkbox"/> Tidak No </div> <div>Date 1st diagnosed</div> </div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 10px;"></div> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div>Diabetes Mellitus</div> <div> <input type="checkbox"/> Ya Yes </div> <div> <input type="checkbox"/> Tidak No </div> <div>Date 1st diagnosed</div> </div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 10px;"></div> <div style="display: flex; justify-content: space-between;"> <div>Others</div> <div> <input type="checkbox"/> Ya Yes </div> <div> <input type="checkbox"/> Tidak No </div> <div>Name of illness:</div> </div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 10px;"></div> <div style="text-align: right;"> Date 1st diagnosed <div style="border-bottom: 1px solid black; height: 15px; width: 100%;"></div> </div>								
<p>h. Adakah keadaan ini berhubung kait dengan <i>Is the condition related to</i></p> <p>(i) Mengandung <i>Pregnancy</i></p> <p>(ii) Ketidaksiuman <i>Insanity</i></p> <p>(iii) Kecacatan semasa lahir <i>Congenital or Birth Defect</i></p> <p>(iv) Human Immunodeficiency Virus (HIV) / AIDS <i>Human Immunodeficiency Virus (HIV) / AIDS</i></p>	<div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div> <input type="checkbox"/> Ya Yes </div> <div> <input type="checkbox"/> Tidak No </div> </div> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div> <input type="checkbox"/> Ya Yes </div> <div> <input type="checkbox"/> Tidak No </div> <div>Date 1st diagnosed</div> </div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 10px;"></div> <div style="display: flex; justify-content: space-between; margin-bottom: 10px;"> <div> <input type="checkbox"/> Ya Yes </div> <div> <input type="checkbox"/> Tidak No </div> <div>Date 1st diagnosed</div> </div> <div style="border-bottom: 1px solid black; height: 15px; margin-bottom: 10px;"></div> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Ya Yes </div> <div> <input type="checkbox"/> Tidak No </div> <div>Date 1st diagnosed</div> </div> <div style="border-bottom: 1px solid black; height: 15px;"></div>								
<p>i. Adakah keadaan yang dialami oleh peserta ini disebabkan lanjutan daripada cubaan membunuh diri atau mencederakan diri sendiri dengan sengaja? <i>Does the participant's condition related to attempted suicide or willful self injury</i></p>	<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Ya Yes </div> <div> <input type="checkbox"/> Tidak No </div> </div>								
<p>j. Nyatakan tempoh pesakit diwadkan. <i>Please state the duration when the patient was warded.</i></p>	<div style="display: flex; align-items: center;"> <div style="text-align: right; font-size: small;">Dari From</div> <div style="margin: 0 5px;"> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> </div> <div style="text-align: center; font-size: x-small;">HH/DD</div> <div style="margin: 0 5px;"> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> </div> <div style="text-align: center; font-size: x-small;">BB/MM</div> <div style="margin: 0 5px;"> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> </div> <div style="text-align: center; font-size: x-small;">TT/YY</div> <div style="margin: 0 5px;">Hingga To</div> <div style="margin: 0 5px;"> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> </div> <div style="text-align: center; font-size: x-small;">HH/DD</div> <div style="margin: 0 5px;"> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> </div> <div style="text-align: center; font-size: x-small;">BB/MM</div> <div style="margin: 0 5px;"> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> </div> <div style="text-align: center; font-size: x-small;">TT/YY</div> </div>								
<p>k. Nyatakan kesemua tempoh pesakit diwadkan <i>Please state all of the duration when the patient was warded</i></p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <th style="width: 30%; text-align: center;">Tarikh Kemasukan ke Wad</th> <th style="text-align: center;">Penyakit</th> </tr> <tr> <td style="text-align: center;"><i>Warded Duration</i></td> <td style="text-align: center;"><i>Diagnosis</i></td> </tr> <tr> <td style="height: 20px;"></td> <td></td> </tr> <tr> <td style="height: 20px;"></td> <td></td> </tr> </table>		Tarikh Kemasukan ke Wad	Penyakit	<i>Warded Duration</i>	<i>Diagnosis</i>				
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<i>Warded Duration</i>	<i>Diagnosis</i>								
<p>C. PENGAKUAN / DECLARATION</p> <p>Saya mengaku bahawa sepanjang pengetahuan keterangan di dalam laporan ini adalah benar dan betul dalam semua aspek. <i>I hereby declare that to the best of my knowledge and belief the foregoing particulars in this report are true and correct in every aspect.</i></p> <div style="display: flex; justify-content: space-between; margin-top: 50px;"> <div style="width: 30%; border-top: 1px dashed black; text-align: center;"> Tandatangan Doktor / <i>Signature of Doctor</i> </div> <div style="width: 30%; border-top: 1px dashed black; text-align: center;"> Cop Rasmi Hospital / <i>Hospital Official Stamp</i> </div> <div style="width: 30%; border-top: 1px dashed black; text-align: center;"> Tarikh / <i>Date</i> </div> </div>									