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BAHAGIAN II – KENYATAAN DOKTOR YANG MERAWAT (KENYATAAN TENTANG KEHILANGAN UPAYA MENYELURUH)
PART II – ATTENDING PHYSICIAN'S STATEMENT (STATEMENT OF TOTAL AND PERMANENT DISABILITY)

1. (a) Nama Pesakit :
Name of patient :

(b) No. Polisi :
Policy numbers:

(c) Pekerjaan :
Occupation :

(d) Nombor Kad Pengenalan/ *NRIC* :
Baru/ *New:*
Lama/ *Old:*

Sila semak No. Kad pegenalan untuk mengesahkan identity pesakit
(*Please verify the NRIC to ensure the identity of the patient)*

Bahagian ini perlu diisi jika hilang upaya disebabkan oleh kemalangan / *To be completed if disability was caused by an accident*

2. (a) Tarikh kemalangan:
Date of accident :

(b) Masa Kemalangan: pagi/ ptg
Time of accident: *am/pm*

(c) Tempat kemalangan:
Place of accident:

(d) Jenis kemalangan:
Nature of accident:

3. (a) Tarikh kali pertama keadaan ini dirujuk kepada anda:
Date you were first consulted for this condition:

(b) Apakah tahap kecederaan yang dialami:
What was the extent of injuries?

(c) Adakah kecederaan melibatkan amputasi? Jika ya, sila nyatakan dengan lengkap.
Was there any amputation involved? If yes, please provide details

(d) Adakah pesakit dibawah pengaruh dadah/alcohol?
Was the patient under influence of drugs/alcohol?

Bahagian ini perlu diisi jika hilang upaya disebabkan oleh Penyakit / *To be completed if disability was caused by illness*

4. (a) Apakah gejala/tanda/aduan dan bilakah ia mula-mula timbul?
What was the symptoms/ signs/ complaints and when did they first appear?

(b) Tempoh gejala bila kali pertama keadaan ini dirujuk.
Duration of the symptom when first consulted.

(c) Sila nyatakan butir diagnosis dengan lengkap dan tepat.
Please provide full and exact details of the diagnosis.

(d) Tarikh pertama diagnosis :
First diagnosed on

(e) Bilakah kali pertama pesakit diberitahu tentang penyakit ini?
On which date did the patient first become aware of this illness?

(f) Sila berikan keputusan bagi apa-apa kajian yang dilakukan dan lampirkan salinan bagi apa-apa laporan yang berkaitan.
Please give results of any investigations performed and attach copies of any relevant reports that are available.

(g) Apakah rawatan atau rawatan susulan yang dijalankan sekarang?
What treatment or further management is the patient currently under?

5. Adakah anda tahu mengenai apa-apa penyakit atau keadaan berkaitan yang dialami oleh pesakit? Sila nyatakan penyakit atau keadaan tersebut dan bila diagnosis dibuat.
Have you any knowledge of the patient suffering from other illness or related condition? Please specify the illness or condition and when was it diagnosed.

6. Dari rekod pesakit, siapakah yang merawatnya (tidak terkecuali apa-apa penyakit) sebelum hilang upaya bermula.
From your patient's records, whom did the patient see for treatments (regardless of illness) prior to the onset of such disability.

Nama & alamat *Name & address*	Tarikh *Date*	Aduan *Complaints*	Rawatan *Treatment*

7. Adakah pesakit dirujuk oleh doktor lain? Jika ya, sila berikan nama dan alamat doktor tersebut.
Was patient a referral case? Please provide the details of the referring doctor (name and address)

8. Adakah pesakit menjalani apa-apa proses pemulihan? Adakah pesakit mempunyai peluang sembuh?
Is the patient undergoing any form of rehabilitation? What are the chances of recovery?

9. Adakah anda menjangka sebarang keadaan fisiologi yang akan menjejaskan secara kekal peluang pesakit untuk bekerja semula.
Are you anticipating any physiological condition that would permanently effect patient to resume employment

10. Bilakah anda mula-mula merawat pesakit dan bila tarikh rawatan terakhir?
When did you first treat the patient? And when was the last consultation date?

Tarikh pertama/ *first date :*

Tarikh Terakhir / *last date :*

11. Jangkaan pemulihan dalam tempoh 12 bulan akan datang?
What is the expected recovery in the next 12 months?

12. Pada pendapat anda, adakah pesakit ini mempunyai peluang pekerjaan yang bersesuaian dengan kelulusan, latihan dan pengalamannya?
In your opinion, could the patient resume any work for which he/ she is reasonably fitted by education, training and experience? If yes, please specify.

13. Adakah hilang upaya Pesakit sudah pulih, semakin baik, tiada perubahan atau semakin buruk?
Is the disability recovered, improved, stationary or deteriorates?

☐ Pulih/ *Recovered* ☐ Bertambah Baik/*Improved*

☐ Tiada perubahan/ *No Improvement* ☐ Bertambah Buruk/ *Deteriorating*

14. Adakah hayat yang diinsuranskan berada di hospital / rumah?
Is the Life Assured confined to hospital / home?

15. Adakah kehilangan upaya telah menyebabkan pesakit menjadi hilang upaya secara :
Does this disability render the patient to be:-

☐ Hilang upaya seluruh *Totally disabled* ☐ Hilang upaya sebahagian *Partially disabled*

☐ Terlalu awal untuk menentukan *To early to determine*

Tarikh pemeriksaan baru/ Next review date :

16. Penilaian Aktiviti Harian/ Activities of Daily Living Assessment
(Note : '***Yes'*** if patient is **able** to perform & '***No'*** if patient is **unable** to perform)

			Yes	**No**
i)	Perpindahan *Transfer*	Berkemampuan duduk dan berdiri tanpa bantuan *Getting in and out of a chair without requiring physical assistance*	☐	☐
ii)	Pergerakan *Mobility*	Berkebolehan untuk bergerak dari bilik ke bilik tanpa bantuan *The ability to move from room to room without requiring physical assistance*	☐	☐
iii)	Kontinens *Continence*	Berkemampuan untuk mengawal fungsi pembuangan kumuhan bagi mengekalkan kebersihan diri *The ability to voluntarily control bowel and bladder function such as to maintain personal hygiene*	☐	☐
iv)	Pemakaian *Dressing*	Memakai dan menanggalkan pakaian tanpa bantuan orang lain *Putting on and taking off all necessary items of clothing without requiring assistance of another person*	☐	☐
v)	Mandi *Bathing / Washing*	Berkemampuan untuk membersihkan diri (mandi tanpa bantuan orang lain) *The ability to wash, bath or shower (including getting in or out of the bath or shower) or wash by any other means.*	☐	☐
vi)	Pemakanan *Eating*	Dapat menjamah makanan yang dihidangkan *All tasks of getting food into the body once it has been prepared*	☐	☐

Sekyen Tambahan : Kehilangan Penglihatan / Buta (Sekiranya ada) / ***Additional Section* : *Loss of Vision / Blindness (If any)***

1. (a) Please state the visual acuity of both eyes : **Left eye : ……………………………………** **Right eye : ………………………….**

(b) Were there any associated systemic disease ? ☐ Yes ☐ No

If yes, please state: ………..

(c) Is there any residual vision in either eye? ☐ Yes ☐ No

If yes, please provide details of the degree of vision loss [please express numerically where possible]

Left eye : ……………………………………………………………………….

Right eye : ………………………………………………………………………

(d) Is there any surgery available that could reinstate vision in either or both eye of this patient? ☐ Yes ☐ No

If yes, please state the type and date when the surgery was done/planned for this patient :

……… on .... (dd/mm/yy)

(e) Please confirm whether if the blindness in this patient is of : ☐ One eye ☐ Both eyes …………………….. (Rt / Lt)

(f) Is patient currently using spectacles? ☐ Yes ☐ No

If yes, kindly state the power of his/her glasses : **Rt lense : ……………………………** **Lt lense : ……………………………….**

I hereby certify that I *have / have not seen the claimant's Identity Card number as stated above and that the photograph of which bears resemblance to the claimant whom I have examined.

I hereby certify that the answers above are full, complete and true.

Name : ………….. ………………………………………………………………

………………………………………………
(Signature of Medical Officer in charge)

Qualification: ………………………………………………………………………

Official Hospital Stamp :

Date : ……………………………………………………………………………