PERKESO

PERTUBUHAN KESELAMATAN SOSIAL
MENARA PERKESO
281, JALAN AMPANG,
50538 KUALA LUMPUR
TEL. AM : 03-4264 5000 FAKS : 03-42568325

LAPORAN PERUBATAN UNTUK MEMOHON PENYAKIT KHIDMAT
(MEDICAL REPORT ON OCCUPATIONAL DISEASE)

Personal Details

Name : _____ Date of Birth: ☐☐☐☐☐☐☐☐

_____ New I.C No. : ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Sex : ☐ Male ☐ Female

Phone No. : _____ _____

Address : _____

Name & Place of Workplace/Employer : _____

Phone No. : _____ Fax No. : _____ E-mail : _____

Date of medical examination: _____ Place of medical examination: _____

Name of Doctor / Specialist & Qualification : _____

_____

Are you the doctor / specialist who treats the patient? ☐ Yes ☐ No If yes how long have you been treating the patient? _____

Present medical history

Details of the chief complaint. Is it related to the hazard exposures in the workplace?

Past Medical History (Including previous medical and surgical conditions)

Review of Systems (Other than the main system)

Relevant Family / Personal & Social (hobbies, smoking, medication)/Environmental History

Occupational History

1. Type of Work/Industry	2. Job title (specify the work done)	3. Employment dates	4. Hazards
a) b) c)			

Clinical Examination: General and Specific examination of target organs.

Review of other systems examination.(Respiratory, skin, Cardiovascular, GIT(liver,spleen), Kidney, mental status, central / peripheral nervous system, others(specify)

INVESTIGATION Workplace monitoring results.

Mention the specific hazards that are present in the workplace and the amount of personal & workplace exposure levels. For chemicals attach summary of Chemical Health Risk Assessement Report (CHRA). For noise attach noise report/map by competent person.

General Laboratory Tests

Blood & Urine examination.

Specify/confirmatory tests

(e.g Chest X-Ray, Spirometry, Serial Audiogram, ABER, Tympanogram, Skin Patch test etc.

FINAL DIAGNOSIS OF OCCUPATIONAL DISEASE (According to International Classification of Diseases ICD 10)

Date of diagnosis:

I certify that the above statements & findings are true.

Has the case been notified to Dept. of Occup. Safety & Health

Date :

☐ No ☐ Yes When

Full Name and Qualification

_____

_____

_____

Signature of Doctor / Specialist

Offical Stamp of Hospital / Medical Centre

This form shall be filled in by the Occupational Health Doctor