KUMPULAN WANG SIMPANAN PEKERJA

LAPORAN PERUBATAN PESAKIT UNTUK PENGELUARAN HILANG UPAYA KWSP

PERHATIAN : MANA-MANA ORANG YANG MEMBUAT KENYATAAN YANG TIDAK BETUL ATAU TIDAK BENAR ATAU MENGEMUKAKAN ATAU MEMBERIKAN DOKUMEN PALSU ADALAH MELAKUKAN SUATU KESALAHAN DAN BOLEH DIDENDA ATAU DIPENJARA ATAU KEDUA-DUANYA (SEKSYEN 59 AKTA KWSP 1991)

NOTA

i) Laporan ini hendaklah disediakan oleh pengamal perubatan yang merawat penyakit yang paling kritikal dihidapi oleh pesakit.

ii) Butiran dan hasil pemeriksaan yang dinyatakan di dalam laporan ini mestilah di dalam tempoh 6 bulan dari tarikh laporan ini ditulis.

iii) Laporan ini diperlukan bagi memenuhi syarat di bawah skim Pengeluaran Hilang Upaya KWSP dan akan digunakan untuk tujuan tersebut semata mata.

iv) Tuan adalah digalakkan untuk menyediakan laporan ini secara bertaip menggunakan salinan lembut yang boleh diperolehi dari laman sesawang www.kwsp.gov.my

(SILA SEDIAKAN LAMPIRAN JIKA RUANGAN TIDAK MENCUKUPI)

1.	Nama Pesakit *(Patient's Name)*	
2.	No. Kad Pengenalan / No. Paspot *(Identity Card No.) / Passport No.*	
3.	Umur / Jantina *(Age / Sex)*	
4.	No. Pendaftaran Pesakit *(Patient's Registration No.)*	
5.	Tarikh Mula Rawatan *(Start Of Treatment Date)*	
6.	Tarikh Masuk Hospital (Jika Ada) *(Admission Date, If Any)*	
7.	Tarikh Keluar Hospital (Jika Ada) *(Discharge Date, If Any)*	
8.	Adakah anda pengamal perubatan yang merawat pesakit ini? *(Are you the doctor that treated the patient?)*	Ya *(Yes)* ☐ Tidak *(No)* ☐
9.	Jika 'Ya', nyatakan tempoh jangka masa anda merawat pesakit ini. *(If 'Yes', how long have you been treating the patient)*	
10.	Tarikh rawatan / pemeriksaan terakhir dibuat *(Last date of treatment / examination)*	
11.	Jika 'Tidak', nyatakan nama pengamal perubatan yang merawat pesakit ini dan no.telefon untuk dihubungi (jika ada). *(If 'No', please state the name of the treating doctor and contact number, if any)*	

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12.	Sejarah Perubatan Pesakit *(Patient's Medical History)*	
13.	Pemeriksaan Fizikal Am *(General Physical Examination)*	
14.	Ringkasan pemeriksaan yang releven. Contoh: X-Ray, Echo, MRI, ECG, EMG, EEG, HPE, blood test dan lain-lain. *(Summary of Relevant Investigation e.g. X-Ray, Echo, MRI, ECG, EMG, EEG, HPE, blood test, etc)* Sila kepilkan bersama salinan keputusan ujian pemeriksaan *(Please attach a copy of the test result)*	
15.	Diagnosa *(Diagnosis)*	
16	Kaedah Rawatan *(Type Of Treatment)*	a) Ringkasan prosedur yang dijalankan ke atas ahli *(Summary of procedures carried out on patient)* b) Ubatan dan lain-lain rawatan yang diberikan kepada pesakit *(Drugs and other medications prescribed to patient)*

17.	Lain-Lain Maklumat *(Other related Information)*	a) Kemajuan pesakit semasa di bawah rawatan doktor dan rawatan susulan *(Progress of patient while under the care including follow-up)* b) Keadaan pesakit pada masa terakhir dirawat oleh doktor *(Condition of the patient as last observed)*
		c) Prognosis keadaan *(Prognosis of the condition)* d) Sijil Perubatan diberi dan tarikh (dalam tempoh setahun) *[Medical Certificates given and date (within a year)]*

SOALAN NO 18 –21 ADALAH KHUSUS UNTUK LAPORAN KE ATAS PESAKIT PSIKIATRI

Nota:Penilaian untuk laporan perubatan bagi pesakit psikiatri hanya boleh dibuat oleh pakar psikiatri sahaja.

(QUESTIONS NO. 18-21 ARE SPECIFICALLY FOR PSYCIATRIC PATIENTS)

Note: The assessment for a psychiatric patient can only be done by a psychiatric specialist

18.	Adakah anda seorang pakar psikiatri? *(Are you a psychiatric specialist?)*	Ya *(Yes)* ☐ Tidak *(No)* ☐
19.	Berapa lamakah tempoh anda merawat pesakit ini? *(How long have you been treating this patient?)*	
20.	Sewaktu pemeriksaan untuk tujuan laporan ini dibuat,adakah pesakit ini berada didalam keadaan keredaan atau episod kambuh akut? Nota: Pemeriksaan untuk tujuan laporan ini hanya boleh dibuat ketika pesakit berada didalam keadaan reda sahaja) *(At the time of examination for the purpose of writing this report, was the patient in remission or in an acute relapse episode?)* *Note: Assessment for the purpose of this report can only be done when the patient is in remission)*	
21.	**SILA LENGKAPKAN "THE PERSONAL AND SOCIAL PERFORMANCE (PSP) SCALE" SEPERTI DI LAMPIRAN 1** *(Please complete the Personal and Performance Scale as per Appendix 1.)*	

22.	Perakuan Pengamal Perubatan *(Statement of medical practitioner)*	Saya mengesahkan bahawa pesakit ini adalah :- *(I certify that this patient is :-)* ☐ Dalam kesihatan baik atau sedang pulih dan akan berupaya menjalankan tugas *(In good health or is recovering and will be able to work)* ☐ Menghidap ..... dan kelemahan akal / tubuh beliau akan menjadi hilang upaya serta menyebabkan beliau tidak berupaya menjalankan tugasnya seperti definisi di bawah. *(Suffers from ..... and this mental / fizikal condition makes him / her incapacitated to work as per definition below* ☐ Dirujuk ke Lembaga Perubatan KWSP untuk pemeriksaan *(To be referred to EPF Medical Board for assessment)* Definisi Hilang Upaya KWSP *(EPF Incapaciation Definition)* **Tidak berupaya dari segi fizikal atau mental selepas mencapai Pemulihan Perubatan Maxima (MMI) atau kehilangan keupayaan fungsional kekal untuk memperolehi pekerjaan (*employability*) yang setara dengan pekerjaan atau pendapatan terakhir.** *Physically or mentally incapacitated, after achieving Maximal Medical Improvement (MMI) or having permanent functional loss, to obtain employment (employability) that is comparable to the last employment or earnings.* **NOTA:** Tahap hilang upaya untuk **kehilangan keupayaan fungsional kekal** perlu dinilai berdasarkan Garispanduan Hilang Upaya KWSP. *The incapacitation level for **permanent functional loss** is to be ascertained based on the EPF Total Incapacitation Assessment Guideline for Incapacitation Withdrawal.* Definisi MMI *(MMI Definition)* **Pemulihan Perubatan Maksima (MMI) adalah suatu keadaan atau situasi yang stabil dan tidak mungkin bertambah baik secara substansil, dengan atau tanpa rawatan perubatan.** *A condition or state that is stable and unlikely to improve substantially , with or without medical treatment.*
23.	Ruangan ini untuk dilengkapkan oleh pengamal perubatan sekiranya berkaitan. *(To be filled if necessary)*	Adakah ketidakupayaan itu daripada segi klinikal menghalang pesakit daripada menguruskan hal-ehwal dirinya sendiri? *(Does the member's incapacitation disable him clinically from managing himself?)* Ya *(Yes)* ☐ Tidak *(No)* ☐ Ulasan: *(Comments)* _____ _____ _____

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

..... **TARIKH : .....**
TANDATANGAN & NAMA PENGAMAL PERUBATAN *DATE*
DAN NO. MPM SERTA COP RASMI HOSPITAL/KLINIK
SIGNATURE, DOCTOR'S NAME, MPM NO. AND HOSPITAL/CLINIC OFFICIAL STAMP

APPENDIX 1

PERSONAL AND SOCIAL PERFORMANCE SCALE

a) Assessment of the incapacitation level for Mental and Behavioral Disorder is based on The Personal and Social Performance (PSP) scale which assesses the psychological and occupational function of the patient. There are four main domains of functionality to be assessed.

i. Self-care
ii. Socially useful activities (including work)
iii. Social relationship
iv. Disturbing and aggressive behaviour

b) There are two different sets of operational criteria to judge the degree of difficulties. One for the A-C areas and one specific to the D area.

c) The elaboration on the degrees of severity is as in Appendix 2

PERSONAL AND SOCIAL PERFORMANCE SCALE

(PLEASE TICK THE RELEVANT COLUMNS BASED ON THE DEGREES OF SEVERITY AS IN APPENDIX 2)

Additional requirements:

		Absent	Mild	Manifest	Marked	Severe	Very severe
A	Self - care						
B	Socially useful activities (including work and study)						
C	Personal and Social Relationships						
D	Disturbing and Aggressive Behaviors						

NOTE

- **Duration of treatment for illness not less than 2 continuous years.**
- **Confirmation from a psychiatric specialist.**
- **Assessment is to be done when the patient is in remission, and not while he/she is in an acute relapse episode.**

PERSONAL AND SOCIAL PERFORMANCE SCALE DEGREES OF SEVERITY

There are two different sets of operational criteria to assess the degree of difficulties: One for the A-C areas and one specific to the D area.

DEGREES OF SEVERITY AREAS A-C	DEGREES OF SEVERITY AREA D
i) Absent – no impairment at all	i) Absent – no impairment at all
ii) Mild – defined here as known only to someone who is very familiar with the person	ii) Mild - corresponding to mild rudeness, unsociability or whingeing
iii) Manifest - but not marked, difficulties clearly noticeable by everyone, but not interfering substantially with the person's ability to perform his/her role in that area, given the person's socio-cultural context, age, sex, and educational levels.	iii) Manifest - such as speaking too loudly or speaking to others in a too-familiar manner, or eating in a socially unacceptable manner
iv) Marked - difficulties interfering heavily with role performance in that area; however, the person is still able to do something without professional or social help, although inadequately and/or occasionally, if helped by someone, he/she may be able to reach the previous level of functioning	iv) Marked - insulting others in public, breaking or wrecking objects, acting frequently in a socially inappropriate but not in a dangerous way (e.g. stripping or urinating in public)- <u>not occasionally</u>
v) Severe - difficulties that make the person unable to perform any role in that area, if not professionally helped, or lead the person to a destructive role; however, there are no survival risks.	v) Severe - frequent verbal threats or frequent physical assaults, without intention or possibility of severe injuries- <u>not occasionally</u>
vi) Very severe - impairments and difficulties of such intensity to endanger the person's survival.	vi) Very severe - defined as aggressive acts, aimed at or likely to cause severe injuries- <u>not occasionally</u>

<u>NOTE</u>

The disturbing behavior has to be considered only occasionally if it has taken place only 1-2 times in the period and mental health professionals and caregivers believe that it is very unlikely to happen again in the next six months. If the disturbing behavior is judged "occasional", the score should be decreased by 1 (e.g. severe becomes marked).