

TRANSMISSION

FORM MM201 (Part I)

CRD GL Serial No.

Previous GL Serial No.

Date/Time of Issuance Attention Tο

: 24110516141669

: 24110516141669 05/11/2024 16:14:16.841

Visit Type DR VINCENT WONG CHUN-WEI FOR ADMISSION DIE PORTO Appointment Date SUNWAY MEDICAL CENTRE SDN BHD

Sp/Hosp. Fax No. 0374911412 Other Fax No. 0374919191 By Hand/Courier/Mail

INITIAL GL ADMISSION ' 04/11/2024 ; . .

#### **GUARANTEE LETTER ("GL")** GL Validity Period:

To be utilized until 18/11/2024

ii) For one (1) Inpatient admission not exceeding five (5) days.

iii) For extension of admission, a new GL must be obtained upon expiry of five (5) daysvalidity.

Name of Patient:	NRIC No.:
DAYALAN A/L SATHIAMUTTY	750313025181
Name of Employee:	Relationship:
DAYALAN A/L SATHIAMUTTY	EMPLOYEE
Name of Employer:	Program Type:
MALAYSIAN COMMUNICATIONS AND MULTIMEDIA COMMISSION (MCMC)_IP	INSURED
PMCare Member ID;	Benefit Plan: MCMC_IPB
IP750313025181-I	HP_(R&B350)_80KAL

This is to acknowledge that PMCare Sdn Bhd undertakes to make payment for Admission expenses incurred for abovenamed patient NOT EXCEEDING the following limits stated in Item No. 2.

The abovenamed patient is entitled to: 2.

A total limit of not more than	2,500.00 INITIAL LIMIT
A daily Room & Board charges inclusive of Meals & Tax of not more than	350.00
Intensive Care Unit	As Charged
Surgical fees of not more than	0.00
Anesthetic fees of not more than	0.00
Hospital Ancillary Services of not more than	0.00
A daily In-Hospital Physician Visit of not more than	0.00
Delivery Limit of not more than	N/A

Diagnosis (Provisional or Primary)

DENGUE FEVER [CLASSICAL DENGUE]

- Kindly note that:
  - Expense entitlement is only for or directly related to medical/surgical condition referred to the Diagnosis as per above Item No.3.

Maternity Benefits coverage does not include expenses incurred for newborn beyond prenatal period. b.

- c. PMCare will not pay or be responsible for any expenses in excess of the above entitlement or incurred for non-entitlement as indicated above. The excess amount must be recovered by the hospital from the patient upon their discharge, to be advised in our Discharge
- Payment of claim is subject to timely submission of complete documents, i.e. within seven (7) days from date of service or discharge.

For extension of admission, the hospital must contact PMCare.

Kindly upload to our Medibase portal your final itemized bill, with diagnosis and surgical procedures done, so that we can advise you better on theactual coverage, bills and payment.

Please attach the completed form MM201 (Part I & II) together with your invoice for payment.

Please note that the following non-medical items are under exclusion:

Congenital Anomalies; Birth Control & Infertility investigation or treatment; Sexually Transmitted Disease; A.I.D.S; Cosmetic Surgery; Psychiatric.

Disorder; and Dental Care. For complete listing, please refer to the Working Guidelines.

Yours faithfully,

For and on behalf of PMCare Sdn Bhd

..... Authorised Signatory I, the abovenamed and/or on behalf of my dependent hereby consent to the release of medical report and/or information to PMCare Sdn Bhd and my Employer, and/or Payor for daims processing, adjudication, payment, and

reporting.

Name :

NRIC No.:

350713-02-5789

PMCARE SDN BHD (458443-P)

No.1, Jalan USJ 21/10, UEP Subang Jaya, 47630 Selangor, Malaysia, General Line: 03-8026 6888 Careline: 03-8026 7799 Careline Centre Fax: 03-8023 9999 Email:gl@pmcare.com.my

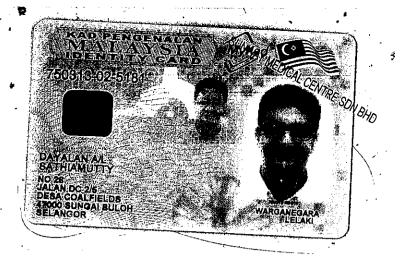
# **PRE-AUTHORISATION FORM**/Borang Pra-kebenaran Private and Confidential / Sulit dan Persendirian PM Care Sdn Bhd Careline Call Centre: 03-8026 7799 Fax Server: 03-8022 3000



	pleted by Patient/Claimant)					
1. Patient Name:	ık diisi oleh Pesakit / Penuntut)	<u>.</u>	2. NRIC (Old & New):			
Nama Pesakit	AND ML SAFT	-1 Amerry	K.P. (Lama & Baru)	13180B1802F		
3. a. Date of Birth: Tarikh lahir	12/3/1	9 fc Umur	c. Sex: Jantin	Male ☐ Female Laki-laki Perempuan		
No. Polisi / No.	nber ID/ Certificate No/ Plan/ Cor Ahli / No. Sijil / Pelan / Nama Sya ^ C M		5. Admission / Planned Ac Tarikh kemasukan hosp			
6. Hospital Name: Nama Hospital	SUNWAY MEDICAL CENT	RE SON BHD	7. Name of Attending Do Nama Doktor yang me	ctor/ Speciality: rawat/ Kepakaran:		
1	n (tick) and answer accordingly jawab soalan yang berkenaan					
	a. Occurred on: Date: Berlaku pada Tarikh		ime: aasa p	am		
8. Accident <i>Kemalangan</i>	b. Details of Accident: Butir-butir kemalangan					
}	a. Symptoms first appeared on Tarikh simptom tersebut ber		<i>ll</i>			
9. Illness	b. Doctor(s) consulted for this					
Penyakit	Doktor-doktor yang dilawati	•				
	c. Doctor's or Clinic Contact(Ad Alamat & Telefon Doktor	dress & Telephone):				
10. Declaration	and authorization	<del></del>				
I declare that the answe	rs given above are true and complete to t	the best of my knowledge and belief.				
representative shall not	I understand the delivery of this form is in no way an admission of claim by PMCare Sdn Bhd/Payor Company and payment to the hospital by PMCare Sdn Bhd/Payor Company or its representative shall not be construed as final admission of claim by PMCare Sdn Bhd/Payor Company for this and any further claims arising, PMCare Sdn Bhd/Payor Company reserves all rights for evaluation as appropriate.					
I am fully aware of the entitlement under the sa	limits as to my/covered person's medica aid policy contract, or that is not covered i	l/Takaful entitlement under the abo by the same.	ve-mentioned policy. I hereby und	ertake to settle/relmburse any medical expenses exceeding my		
consulted, other person- Company or its repr company, subsidiaries associations/federations incapacity in so far as le I agree that in the ever	I hereby irrevocably authorize any organization, institution, or Individual that has any record or knowledge of my health and medical history or treatment or advice that has been or may hereafter be consulted, other personal information or details of related accident/injury, to disclose to PMCare Sdn Bhd/Payor Company or its representative such Information. I agree that PMCare Sdn Bhd/Payor Company or its representative may use or disclose any of the information collected or held to third parties (within or outside Malaysia, including PMCare Sdn Bhd/Spayor Company's parent company, subsidiaries or any other associated companies within the PMCare Sdn Bhd/Payor Company Group, reinsurers/retakaful, medical examiners, claims Investigators and industry associations/federations etc.) in relation to this claim. This authorization shall bind my/the covered person's successors and assigns and remain valid notwithstanding my/ covered person's incapacity in so far as legally possible. A photocopy of this authorization shall be valid as the original.  I agree that in the event I make, or have in the past made, any false or untrue statement and/or suppressed and/or concealed any material facts in respect of my/the covered person's condition, PMCare Sdn Bhd/Payor Company shall absolutely forfeit my/the covered person's right to compensation and further reserves the right to recover any amounts paid earlier as a result thereof.					
Pengisytiharan dan p	emberikuasa		-			
Saya mengisytiharkan ba	ahawa jawapan yang diberikan di atas ada	alah benar dan lengkap setakat peng	etahuan dan kepercayaan saya.			
bersetuju bahawa b	Saya memahami bahawa penyerahan borang ini, tidak sama sekali boleh dianggap sebagai persetujuan tuntutan saya/orang yang dilindungi ke atas PMCare Sdn Bhd/Syarikat Pembayar dan saya bersetuju bahawa bayaran kepada hospital oleh PMCare Sdn Bhd/Syarikat Pembayar atau waklinya tidak akan ditafsirkan sebagai persetujuan muktamad tuntutan ke atas PMCare Sdn Bhd/Syarikat Pembayar dan PMCare Sdn Bhd/Syarikat Pembayar berhak menjalankan penilaian sewajarnya berhubung tuntutan ini atau apa-apa tuntutan yang timbul selanjutnya.					
Saya memahami sepenuhnya had-had kelayakanTakaful/Perubatan saya di bawah Polisi yang tersebut di atas. Saya dengan ini berjanji akan menyelesaikan sebarang amaun yang melebihi had kelayakan saya, yang tidak dilindungi oleh Polisi berkenaan.						
kesihatan dan latar bel Bhd/Syarikat Pembay maklumat yang dikump reinsurans/retakaful, pe penama saya/ nyawa ya	lakang atau rawatan atau nasihat peru ar atau wakilnya segala maklumat terse oul atau dipegang kepada pihak k meriksa perubatan, penyiasat tuntut ang dilindungi dan kekal sah meskiput a saya membuat pengakuan palsu at	batan saya/orang yang dilindungi, but. Saya bersetuju membenarkan etiga (di dalam atau di luar Mali an dan pertubuhan/persekutuan in a setelah kematian saya/orang yang	yang telah atau mungkin kemuc PMCare Sdn Bhd/Syarikat Pembay nysia, termasuk syarikat induk, z dustri dil.) berkaitan dengan tunt n dilindungi setakat yang dibenark	yang mempunyai apa-apa rekod atau pengetahuan tentang ilan dari ini dirujuk untuk mendedahkan kepada PMCare Sdn ar atau wakilnya untuk mengguna dan mendedahkan apa-apa anak syarikat atau syarikat berkait dalam Syarikat, syarikat utan ini. Pengesahan ini hendaklah mengikat waris-waris dan an di sisi undang-undang. Salinan pengesahan ini adalah sah, rikat Pembayar berhak membatalkan tuntutan saya dan menarik		
Signature of Patient / 7	andatangan Pesakit	Signature of Covered person/		Signature of Witness / Tandatangan Saksi		
	′	Orang yang dilindungi /Penun	uu. 			
1 / /2	m	1 Johns		4		
Name/ <i>Nama</i> : De	ala Suttant	Name/Nama: 1)279V	CA Il	Name (Name)		
IC No./No. KP: 7	103 K-02-1781	IC No./No. KP. 75071	2-05-116,	Name/Nama: IC No./No. KP.		
Date/ <i>Tarikh</i> : Contact No. / No. Tele	101	Date/ <i>Tarikh</i> : Contact No. / No. Telefon: Relationship to Patient/ <i>Hubu</i> .	J (8 \	Date/ <i>Tarikh</i> : Cr / FC/ Contact No. / No. untuk dihubungi:		
		The second secon	.g werigall i Caurille	İ		

Pent 2 ADMISSION SECTION   To be completed upon admission by Doctor		Corporate Name :				
Admission Date and Time:  Admission No. MRN.  B. Symptoms (Cardillogs reguling admission)  B. Symptoms (Cardillogs reguling admission)  C. Patient Set / Tempor (Pause)  (IAM Dec.)  B. How long is patient aware of the condition.  Patient Set / Tempor (Pause)  (IAM Dec.)  A Any pervisor consultation / Investigation for this symptom / Iliness or related conditions, or other disorders whether in his hospit by the patient referred? If Yes, please provide details below.  C. If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition of the patient provide reasons of demonstration of the condition of the patient provide admission of the condition of the patient provide admission of the condition of the patient of	1.a. Patient name:	SECTION ( To be com	pleted upon adr	nission by Doct	or)	X \
Admission Date and Time:  Admission Date and Time:  B. Expected days of stay T OxeCute Date:  C. Pathol Expected from the Confidence of the Confidence Date:  C. Pathol Expected from the Confidence of the Confidence Date:  C. Pathol Expected Date:  A. Any previous consultation Treatment/ Toxipialization for this symptomy liness or related conditions; or other disordars whether in this hospital provides occasionate of the Confidence Date:  A. Any previous consultation Treatment/ Toxipialization for this symptomy liness or related conditions; or other disordars whether in this hospital provides date before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition of the Confidence Date:  Date:  Dispense indicate Date:  Dispense indicate in your professional opinion how long has the condition of the Oxigence Date:  Admission Boundary Indicated Date:  Burdan Boundary Indicated Date:  Admission B	2. Policy No. / Memb	DATE SATE	Francis	505160st.	rc. Age: ce d. Sex: c	Male h Female
4. Actinisation Date and Time:  6. a. Symptoms / Gendifices regularing adjustance:  6. a. Symptoms / Gendifices regularing adjustance:  6. a. Symptoms / Gendifices regularing adjustance:  6. Date symptoms first appealed:  7. a. Any previous consultation from the provide details below:  6. Date symptoms first appealed:  8. Date first consultation:  9. Was this patient referred? If Yes, phases provide details below:  9. Life in a condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how for ghas the condition be managed under the Outpatient basis: If Yes I Monthly of the patient of Treatment / Hospitalization  9. Dates provide reasons of adminsion:  9. Estimated Total Coets: RM  9. Programory / Ohlabbrich / Interluity / Calesarana section / Interluity of relaped? Q yes a No  9. Estimated Total Coets: RM  9. Estimated Total Coets: RM  9. Programory / Ohlabbrich / Interluity / Calesarana section / Interluity of relaped? Q yes a No  9. Estimated Total Coets: RM  9. Estimated Total Coets: RM  9. Programory / Ohlabbrich / Interluity / Calesarana section / Interluity of relaped? Q yes a No  9. Estimated Total Coets: RM  9. Programory / Ohlabbrich / Interluity / Calesarana section / Interluity / Researance / Interluity / Interluit		me me	17 Company No:	0. 1.00pitu	on Ma (MON)	
S. a. Symptoms (Sentingpe reguling admission:  C. Paulité BP / Temp / Puse:  d. Diew forg is patient sware of the condition:  C. Paulité BP / Temp / Puse:  d. Diew forg is patient sware of the condition:  C. Paulité BP / Temp / Puse:  d. Diew forg is patient sware of the condition:  C. Paulité BP / Temp / Puse:  d. Diew forg is patient sware of the condition:  D. Diew forg is patient sware of the condition.  D. Diew forg is patient sware of the condition.  D. Diew forg is patient sware of the condition.  D. Diew forg is patient sware of the condition.  D. Diew forg is patient sware of the condition.  D. Diew forg is patient sware of the condition.  D. Diew forg is patient sware of the condition.  D. Diew forg is patient sware of the condition.  D. Diew forg is patient sware of the condition.  D. Diew forg is patient sware of the condition.  D. Diew forg is patient sware of the condition.  D. Diew forg is patient sware of the condition.  D. Diew forg is patient sware of the condition for the patient of the patient places indicate in your professional opinion how long has the condition existed before symptoms became apparant to the patient / Hospitalization  D. Diew forg is patient sware of the patient o	4. Admission Date a	nd Time:	~		(367	Date:
c. Pateritis By / Temp / Pulses:  d. Date symptome first appeared.  7. a. Any previous capsulation, freatment / hospitalization for this symptom? limess or orielated conditions, or other disorders whether in this hospit or by the condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition oxisted:  Date  Disease / Disorder  Details of Treatment / Hospitalization  Doutrar / Hospital / Clinic  Doutrar / Hospitalization  Doutrar / Hosp	6. a. Symptoms / Co	nditions requiring admission		, b. How long is pa	atient aware of the conditi	on:
7. a. Any previous consultation / treatment / hospalization for this symptom / illness or related conditions, or other disorders whether in this hospit or any other facilities of the set provide details below:  a. If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed:  Data Disease / Dis	c. Patient's BP / T	emp / Pulse:	~ch yeps	hleel_	2dys-	<b></b>
or any other facilities of New Year, Despension of the symptom / Illness or related conditions, or other disorders whether in this hoppin b. Was this patient referred? If Yes, please provide details below.  O. If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed.  Date of the condition be managed under the Outpatient basis: DYSS DN	d. Date symptoms	first appeared:	u, m	e. Dat	e first consulted:	4,29
C. If this condition existed before symptoms became apparent to the patient, please indicate in your professional opinion how long has the condition existed:  Date  Disease / D	or any other faciliti	es?  Yes  No referred? If Yes, please pr	pitalization for this sy ovide details below:	mptom / illness or rela	ted conditions, or other d	isorders whether in this hospit
d. Can the condition be managed under the Outpetient basis: □Yes □ No  If no glesse provide reasons of admission:  5. a. D. Admitting Diagnosis:  6. a. D. Admitting Diagnosis:  7. Advised patient on 1. I.	1			e patient, please indi	cate in your professional	opinion how long has the
B. a. D. Affording Diagnosis:  D. a Provisional Diagnosis:  D. a Advised patient on J. J. J. J. Advised patient on J.	<u>Date</u> <u>r</u>	Disease / Disorder	Details of Treatme	ent / Hospitalization		Doctor / Hospital / Clinic
8. a. p. Admitting Diagnosis:	d. Can the condition	n be managed under the Ou	utpatient basis: □ Yes	1 DNO	Λ	<del></del>
B. D Provisional Diagnosis:  9. Estimated Total Costs : RM  10. Admission 11. Is the illness (condition related to (please lists (r) if YES).  10. Admission 11. Is the illness (condition related to (please lists (r) if YES).  10. Pregnancy (chilabith / Infertitally / Ceasarean section/ miscarriage  10. Pregnancy (chilabith / Infertitally / Ceasarean section/ miscarriage  10. Pregnancy (chilabith / Infertitally / Ceasarean section/ miscarriage  10. Day Care 10. Influence of Drugs / Albourder  10. Day Care 11. Nervous / Metantal / Emotional / Sleeping Disorder  12. Medical treptment, investigations and Surgical procedure to be performed, if any (please supply copy of all investigation results):  12. Medical treptment, investigations and Surgical procedure to be performed, if any (please supply copy of all investigation results):  13. Any other medical/surgical conditions present? DNO D Yes, details below:  14. Was the patient pregnant at the time of hospitalization? (For Female Cnity)  15. a. If hospitalization was due to injury, please describe circumstances and cause of injury.  16. Please indicate date/time of accident: (ad/imm/yy).  16. Please indicate date/time of accident: (ad/imm/yy).  17. John Section of the separate of the patient for his/her injuries / illness described above and that the facts as stated above represent my medical opinion of his/her position of the properties of the patient of his/her injuries / illness described above and that the facts as stated above represent my medical opinion of his/her position of death of the patient for his/her injuries / illness described above and that the facts as stated by the patient of the patient for his/her injuries / illness described above and that the facts as stated by the patient of the patient for his/her injuries / illness described above and that the facts as stated by the patient of the patient for his/her injuries / illness described above and that the facts as stated by the patient of the patient for his/her condition.  18. Date of Sulfan Jan				/ [V/\	V) 4	11 4
S. Estimated Total Costs: RM  10. Admission requires:  a) Pregnancy / Childbirth / Interflity / YES)  b) ADS / State / Riots  12. Medical treatment, investigation results):  13. Any other medical/surgical conditions present? Pro of Yes, details below:  a) Self-inition injury / Pease supply copy of all investigation was due to injury, please describe circumstances and cause of injury.  b. Please indicate date/time of accident: (ad/mnryy)  b. Please indicate date/time of accident: (ad/mnryy	<b>1</b> 0r	(Mr. 11)	e la	Advis	ed patient on $\sqrt{1/7}$	10
10. Admission   11. Is the lilness / condition related to: (please libk (*/ ) if YES.)   Diease provide details:   Diease provide provide provide de	í	'n ·	1 1	d. Caus	e and pathology underlyir	g the present diagnosis:
Pregnancy / Chilabrith / Infertility / Caesarean section / miscarriage Or any complications arising thereform. Day Care On Patient's Or any complications arising thereform. On Patient's Or any complication of Dental Care / refractive errors correction On Patient's Or Albo's / Neurola / Mential / Emotional / Sleeping Disorder On Patient's Or Albo's / Dental Care / refractive errors correction On Patient's Or Albo's / Dental Care / refractive errors correction On Patient's Or Albo's / Strive / Riots Or A			WC	e. Anv n	Graf	rds − No
Day Care On Influence of Drugs / Alcohol Developer diseases on Influence of Drugs / Alcohol Developer / Al		11. Is the illness / condition	n related to: (please t	JCK ( V ) It VEQ)	51.7	es 🗆 No provide details:
Day Care  Day Care  Dischards electrolary listesess of the control	D.Aospitalisation	Or arry collip	ilications arising then	efrom.	nscarriage	
Con Patient's ()   Cosmetto reason / Dental care / refractive errors correction	,	<ul><li>c) □ influence of □</li></ul>	rugs / Alcohol			
Request    3		,	ntal / Emotional / Sie	eping Disorder		
12. Medical treatment, investigations and Surgical procedure to be performed, if any (please supply copy of all investigation results):  13. Any other medical/surgical conditions present? No Yes, details below:  14. Was the patient pregnant at the time of hospitalization? (For Female Only)  15. a. If hospitalization was due to injury, please describe circumstances and cause of injury:  16. I hereby certify that I have personally examined and treated the Patient for his/her injuries / itiness described above and that the facts as stated above represent my medical opinion of his/her condition.  16. I hereby certify that I have personally examined and address:  17. Undertaking Letter Ref No.: (if available)  18. Date of bischarge 10. Date of surgery / procedure:  19. a. Final Diagnosis:  19. Date of surgery / procedure:  19. In the case of DEATH, please advise Date/ Time and Cause of death:  19. In the case of DEATH, please advise Date/ Time and Cause of death:  19. In the case of DEATH, please advise Date/ Time and Lause of death:  19. Survey MEDICAL CENTRE SDN BID (241855-X)  19. In the case of DEATH, please advise Date/ Time and Lause of death:  19. In the case of DEATH, please advise Date/ Time and Lause of death:  19. In the case of DEATH, please advise Date/ Time and Lause of death:  20. Treatment given / Investigation of his/her condition.		i) alus/SID/	VD/HIV		on	
12. Medical treatment, investigations and Surgical procedure to be performed, if any (please supply copy of all investigation results):  13. Any other medical/surgical conditions present? PNO PYes, details below:  14. Was the patient pregnant at the time of hospitalization? (For Female Only)  15. a. if hospitalization was due to injury, please describe circumstances and cause of injury:  16. I hereby certify that I have personally examined and treated the Patient for his/her injuries / iliness described above and that the facts as stated above represent my medical opinion of his/heroporalition.  16. I hereby certify that I have personally examined and treated the Patient for his/her injuries / iliness described above and that the facts as stated above represent my medical opinion of his/heroporalition.  17. Undertaking Letter Ref No.:(I if available)  18. Date of Discharge.  19. a. Final Diagnosis:  19. a. Final Diagnosis:  19. b. Cause and pathology of the diagnosis:  19. c. cause and pathology of the diagnosis:  19. b. Date of surgery / procedure:  29. Treatment given / Investigation done: (Please supply copy of all investigation results)  20. Treatment given / Investigation that arose (if any):  20. In the case of DEATH, please advise Date/ Time and Cause of death:  20. In the case of DEATH, please advise Date/ Time and Cause of death:  20. Silviw/A/ MEDICAL CENTRE SDN BHD (241855-X)  20. No. 5, Jalan Lagron Seletan Procedure Condition.	Í					
a	12. Medical treatment,	Investigations and Surgical	procedure to be per	formed, if any (please	supply copy of all investi	gation results):
a. since / / / No DYes. months  15. a. If hospitalization was due to injury, please describe circumstances and cause of injury:  b. Please indicate date/time of accident: (dd/mm/yy) / (hrs) Date   (hrs) Described above and that the facts as stated above represent my medical opinion of his/her condition.  Business Office - Discharge, Tower C SUNWAY AMEDICAL CENTRE SDN BHD (341855-X)  Date Name & Signature of AMENding Doctor DR's Contact no and Email address: No.5, Jalan Lagoon SPRISM (Basplas Samiller)  17. Undertaking Letter Ref No.: (If available )   18. Date of Discharge of Dischar	13. Any other medical/s	surgical conditions present?	P □ No □ Yes, details	s below:	14. Was the patient pred	mant at the time of
15. a. If hospitalization was due to injury, please describe circumstances and cause of injury:  b. Please indicate date/time of accident: (dd/mm/yy)  16. / hereby certify that / have personally examined and treated the Patient for his/her injuries / illness described above and that the facts as stated above represent my medical opinion of his/hercondition.  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  DISCHARGE SECTION (To Be completed Upon Discharge by Doctor)  17. Undertaking Letter Ref No.:(If available)  18. Date of Discharge, Toward Lessan, Malaysia  19. a. Final Diagnosis:    Doctor   Discharge   Discharge			_	, ,	hospitalization? (F	or Female Only)
b. Please indicate date/time of accident: (dd/mm/yy)  16. / hereby certify that I have personally examined and treated the Patient for his/her injuries / illness described above and that the facts as stated above represent my medical opinion of his/her condition.  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY ALEDICAL CENTRE SDN BHD (341855-X)  SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY ALEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY ALEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY ALEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY ALEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY AMEDICAL CENTRE SDN BHD (341855-X)  No.5, Jalan Lagons Selated above and that the facts as stated Business Office - Discharge, Tower C SUNWAY AMEDICAL CENTRE SDN BHD (341855-X)  No.5, Jalan Lagons Selated Base as the condition.		Was due to believe	since			months
16. I hereby certify that I have personally examined and treated the Patient for his/her injuries / illness described above and that the facts as stated above represent my medical opinion of his/her condition.  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C Sunway Medical opinion of his/her condition.	701 a. ii nospitalization	was due to injury, please de	escribe circumstance	s and cause of injury:		
16. Thereby certify that I have personally examined and treated the Patient for his/her injuries / illness described above and that the facts as stated above represent my medical opinion of his/her condition.  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C Sunway Medical opinion of his/her condition.  Business Office - Discharge, Tower C Sunway Medical opinion of his/her condition.  Business Office - Discharge, Tower C Sunway Medical opinion of his/her condition.						
Business Office - Discharge, Tower C  SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C  SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  Business Office - Discharge, Tower C  SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  No.5, Jalan Lagoon Seetist, Bespital Stampay  17. Undertaking Letter Ref No.: (If available)  18. Date of Discharge by Doctor)  19. a. Final Diagnosis:  ICD code:  Discharge of Discharge by Doctor)  Discharge by Doctor)  18. Date of Discharge of the diagnosis:  ICD code:  Discharge of Discharge of the diagnosis:  Discharge of Discharge of Discharge of the diagnosis:  Discharge of Discharge	b. Please indicate da	ate/time of accident: (dd/mn	n/yy)/_	/(hrs)	am to r	nm
Date  Name & Signature of Attending Doctor DR's Contact no and Email address:  No.5, Jalan Lagoon SPRISIN/ Bestlan Stampay  17. Undertaking Letter Ref No.:( If available )  18. Date of Discharge 1000  19. a. Final Diagnosis:  ICD code:  20. Treatment given / Investigation done: ( Please supply copy of all investigation results )  21. a. Surgical procedures performed:  b. Date of surgery / procedure:  22. a. Recovery complication that arose (if any):  b. In the case of DEATH, please advise Date/ Time and Cause of death:  3. I hereby certify that I have personally examined and treated the Patient for his / her injuries / illness described above and that the facts as stated business Office - Discharge, Tower C  SUNWAY MEDICAL CENTRE SDN BHID (341655-X)  No.5, Jalan Lagoon Serian Stampay  No.5, Jalan Lagoon Seriango Seriango  No.5, Jalan Lagoon Seriango Seriango  No.5, Jalan Lagoon Seriango  No.5, Jalan Lag	above represent n	ו have personally examine ny medical opinion of his/he	d and treated the Pa	tient for his/her injurie	s / illness described abo	ve and that the facts as stated
DISCHARGE SECTION (To Be Completed Upon Discharge by Doctor)  17. Undertaking Letter Ref No.: (If available)  18. Date of Discharge: 1000 Scientific Darial Ehsan, Malaysia  19. a. Final Diagnosis:  ICD code:  10. Treatment given / Investigation done: (Please supply copy of all investigation results)  20. Treatment given / Investigation done: (Please supply copy of all investigation results)  21. a. Surgical procedures performed:  22. MMA code / PHFSR code:  23. I hereby certify that I have personally examined and treated the Patient for his / her injuries / illness described above and that the facts as stated bove represent my medical opinion of his/her condition.  24. SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  No.5, Jalan I agoon Settling Reptain Stating of Months of Settling Stating Stating Plasting Stating Plasting Stating S				Busin	ess Office - Discharge	, Tower C
DISCHARGE SECTION (To Be Completed Upon Discharge by Doctor)  17. Undertaking Letter Ref No.: (If available)  18. Date of Discharge.  18. Date of Discharge.  19. a. Final Diagnosis:  19. a. Final Diagnosis:  19. b. Cause and pathology of the diagnosis:  19. a. Surgical procedures performed:  20. Treatment given / Investigation done: (Please supply copy of all investigation results)  21. a. Surgical procedures performed:  22. a. Recovery complication that arose (if any):  23. I hereby certify that I have personally examined and treated the Patient for his / her injuries / illness described above and that the facts as stated bove represent my medical opinion of his/her condition.  24. SUNWAY MEDICAL CENTRE SON BHD (341855-X) No.5, Jalan I agnon Selatan Regrets Causes.		DR's Contact no c	SMA DANGER AND	—— SUNW	'AY <u>MEDICAL CENTRE</u>	SDN BHD (341055-X)
19. a. Final Diagnosis:    CD code:	DISCHARGE SECTION	(To Be Completed Upon Did	charge by Doctor)	<del></del>	<del>Sciencor Darul Ehsan</del> M	alaysia
ICD code:  20. Treatment given / Investigation done: ( Please supply copy of all investigation results )  21. a. Surgical procedures performed:  b. Date of surgery / procedure:/  MMA code / PHFSR code:  22. a. Recovery complication that arose (if any):  b. In the case of DEATH, please advise Date/ Time and Cause of death:  3. I hereby certify that I have personally examined and treated the Patient for his / her injuries / illness described above and that the facts as stated bove represent my medical opinion of his/her condition.  SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  No.5. Jalan Laggon Selatan Render Sunway.		(er No.:( If available )		18. Date of Discha	ge <sup>7451</sup> 1000 ×111 2	(p
20. Treatment given / Investigation done: ( Please supply copy of all investigation results )  21. a. Surgical procedures performed:  b. Date of surgery / procedure:/  MMA code / PHFSR code:  22. a. Recovery complication that arose (if any):  b. In the case of DEATH, please advise Date/ Time and Cause of death:  3. I hereby certify that I have personally examined and treated the Patient for his / her injuries / illness described above and that the facts as stated bove represent my medical opinion of his/her condition.  SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  No.5. Jalan Laggon Selatan, Rander Sunway.	19. a. Final Diagnosis:	baju h		b. Cause and patho	logy of the diagnosis:	,
b. Date of surgery / procedure:/  MMA code / PHFSR code:  2. a. Recovery complication that arose (if any):  b. In the case of DEATH, please advise Date/ Time and Cause of death:  3. I hereby certify that I have personally examined and treated the Patient for his / her injuries / illness described above and that the facts as stated bove represent my medical opinion of his/her condition.  Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X) No.5, Jalan Lagnon Selatan Render Supplies.		feet run			11. 21	Ť
MMA code / PHFSR code:  22. a. Recovery complication that arose (if any):  b. In the case of DEATH, please advise Date/ Time and Cause of death:  3. I hereby certify that I have personally examined and treated the Patient for his / her injuries / illness described above and that the facts as stated bove represent my medical opinion of his/her condition.  SUNWAY MEDICAL CENTRE SDN BHID (341855-X)  No.5, Jalan Lagron Selatan Render Supplied.	20. Treatment given / In	vestigation done: ( Please s	supply copy of all inve	estigation results)	4111	
MMA code / PHFSR code:  22. a. Recovery complication that arose (if any):  b. In the case of DEATH, please advise Date/ Time and Cause of death:  3. I hereby certify that I have personally examined and treated the Patient for his / her injuries / illness described above and that the facts as stated business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  No.5. Jalan Laggon Selatan Rander Supplies.	21. a. Surgical procedure	es performed:		b. Date of surgery /	procedure: / /	
b. In the case of DEATH, please advise Date/ Time and Cause of death:  3. I hereby certify that I have personally examined and treated the Patient for his / her injuries / illness described above and that the facts as stated business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  No.5. Jalan Laggon Selatan Rander Supplies.				c. ca.go.y , ,	5.00cdd.re//	<del></del>
b. In the case of DEATH, please advise Date/ Time and Cause of death:  3. I hereby certify that I have personally examined and treated the Patient for his / her injuries / illness described above and that the facts as stated business Office - Discharge, Tower C  SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  No.5. Jalan Laggon Selatan Rander Supplies	MMA code / PHFSR cod 2. a. Recovery complication	e: ation that arose (if anv):				
bove represent my medical opinion of his/her condition.  by stated the Patient for his / her injuries / illness described above and that the facts as stated by siness Office - Discharge, Tower C  SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  No.5, Jalan Lagon Selstan Randor Suppress						
bove represent my medical opinion of his/her condition.  by stated the Patient for his / her injuries / illness described above and that the facts as stated by siness Office - Discharge, Tower C  SUNWAY MEDICAL CENTRE SDN BHD (341855-X)  No.5, Jalan Lagon Selstan Randor Suppress	b. In the case of DEA	TH, please advise Date/ Ti	me and Cause of dea	ath:		
No.5, Jalan Langon Selatan Randor Supuray	bove represent my med	ical opinion of his/her cond	and treated the Patie itien.	ent for his / her injurie	s / illness described abov	e and that the facts as stated
Date Validi J 30000 Selatan Randor Cupway	_				THE PROPERTY OF THE PARTY OF TH	IRP SON RED 1730185521
The state of Attending Ductor 1 200 Colon (10) 1 12 15 Attached to the state of the	Date	Name	& Signature of Attendin	g Doctor 4.	200 Scianoor Dambahara	Randor Cupiusy
Dr Vincent wong		Dr Vi	ncent wons		- 503-7453 1000	11 - Erstmind sprint h

Insurance / Corporate Name :	PMCare
Part 2 ADMISSION SECTION ( To be completed upon admission	by Doctor )
1.a. Patient name: Dayalan All Sathiamutty b. NRI	C: c. Age: Yq d. Sex: Male Female
2. Policy No. / Member ID/ Certificate No.:	3. Hospital Name/ Hospital Contact and Fax No: Admission No. / MRN 100 1192649
4. Admission Date and Time: 4 / 11 / 24	5. Expected days of stay / Discharge Date:
6. a. Symptoms / Conditions requiring admission:	b. How long is patient aware of the condition:
c. Patient's BP/Temp/Pulse:	or regat of Don
d. Date symptoms first appeared://	e. Date first consulted: OS / 11/24
7. a. Any previous consultation / freatment / hospitalization for this symptom / illnes: facilities? ☐ Yes ☐ No. b. Was this patient referred? If Yes, please provide details:	s or related conditions, or other disorders whether in this hospital or any other
c. If this condition existed before symptoms became apparent to the patient, plea	ise indicate in your professional opinion how long has the condition existed:
<u>Date</u> <u>Disease / Disorder</u> <u>Details of Treatment / Hospit</u>	alization Doctor / Hospital/ Clinic
d. Can the condition be managed under the Outpatient basis: Yes No if r	no please provide reasons of admission :
.a. ☐ Admitting Diagnosis:	c. Diagnosis confirmed on// Advised patient on//
or b. ☐ Provisional Diagnosis:  9. Estimated Total Costs: RM	d. Cause and pathology underlying the present diagnosis:
9. Estimated Total Costs: RM	e. Any possibility of relapse? ☐ Yes ☐ No
10. a. Admission requires: 11. Is the illness / condition related to: (plea	se tick v if YES). Please provide details:
a. Pregnancy / Childbirth / Infertility / Ca Or any complications arising therefrom	
Day Care On Patient's Request  Congenital / Hereditary diseases c. Influence of Drugs / Alcohol	
d. Nervous / Mental / Emotional / Sleepi e. Cosmetic reason / Dental care / Refra	
f. AIDS/STD/VD/HIV g. Self-inflicted injuries / Violation of laws	s / Strike / Riots
h. Mone of the above  12. Medical treatment, Investigations and Surgical procedure to be performed, if any	y (please supply copy of all investigation results):
Irolland SHA	
13. Any other medical/surgical conditions present? No Yes, details below:	14. Was the patient pregnant at the time of hospitalization? (For Female Only)
a. since since	/ No □Yes,months
15. a. If hospitalization was due to injury, please describe circumstances and cause	
,	·
b. Please indicate date/time of accident: (dd/mm/yy) / /	(hrs) am pm als/her injuries/illness described above and that the facts as stated above represent
16. I hereby certify that I have personally examined and treated the Patient for him my medical opinion of his/her condition.	als/her injuries/illness described above and that the facts as stated above represent
	Business Office - Discharge Tower C
	Business Office - Discharge, Tower C SUNWAY MEDICAL CENTRE SDN BHD (341855-X)
	no. and Email No.5, Jalan Lagoon Setata เกิดสมบัติสมบ
DISCHARGE SECTION (To Be Completed Upon Discharge by D  17. Undertaking Letter Ref No.(If available):	Poctor) IEL: 603-7493 1000 18. Date of Discharge:
	cause and pathology of the diagnosis:
100 code forty Entrolled Dr	
20. Treatment given / Investigation dane (Please supply copy of all investigation res	uns):
21. a. Surgical procedures performed:	b. Date of surgery / procedure:/
MMA code / PHFSR code:	
22. a. Recovery complication that arose (if any):	
b. In the case of DEATH, please advise Date/ Time and Cause of death:  23. I hereby certify that I have personally examined and treated the Patient for his properties.	nis/ner injuries/lifetss จระปฏิธัยสายอยู่หลาย เกม เกาะ เกม เกม เกาะ เกม
my medical opinion of his/her condition.	SUNWAY MEDICAL CENTRE SDN BHD (341855-X) No.5, Jalan Lagoon Selatan, Bandar Sunway
1	4, 500 Selangor Darul Ehsan, Malaysia TEL: 603-745/1 1000
Date Name & Signatury of Attending Doctor	* Carlo September 2012 (2) 11 H H H
OV Cub Hamilla-	



SUNMAY MEDICAL CENTRE SON ST. KETUA PENGARAH
PENDAFTARAN NEGARA
750313-02-5181-03-01
(A2978695)

(80K)



**FULL AMOUNT** 

FORMAT: SUMMARY

DAYALAN A/L SATHIAMUTTY,

B-19-13,

TREEFALL,

SETIA ALAM,

47000,SHAH ALAM,

SELANGOR DARUL EHSAN, MALAYSIA

BILL NO

: SMC-IP 10093820

BILL DATE

: 08/11/2024

PATIENT NAME

DAYALAN A/L SATHIAMUTTY

IC / PASSPORT NO MEDICAL RECORD NO : 750313025181

VISIT ID

: 1001192649 : SMC-IP 1228074

ENCOUNTER TYPE

INPATIENT

VISIT TYPE
ADMITTING DOCTOR

ŧΡ

: DR VINCENT WONG CHUN-WEI

ADMISSION DATE & TIME
DISCHARGE DATE & TIME

: 04/11/2024 : 08/11/2024 04:24 PM 01:00 PM

EMPLOYEE NAME

PLOTEE NAME

RELATION

EMPLOYEE NO

GL REFERENCE NO

: 24110616141669

CREDIT TERM

: 30,00Days

FINANCIAL TYPE

PMCARE SDN BHD - PMCARE 2020 (IP)

CODE	DESCRIPTION OF SERVICE	100	DATE		GROSS QTY AMOUNT	DISCOUNT	ALLOCATED AMOUNT
HOSPITAL CHARGES	CCC-ACCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCCC			Metado			
ROOM CHAR	<u>GES</u>						
, ACCOMMODA	ATION						
1-1040	PREMIER SINGLE	(	04/11/2024 - 04/11/2024	)	350.00	105,00	245,00
1-1040	PREMIER SINGLE	(	05/11/2024 - 05/11/2024	)	350.00	105.00	245,00
1-1040	PREMIER SINGLE	(	06/11/2024 - 06/11/2024	)	350.00	105.00	245.00
1-1040	PREMIER SINGLE	(	07/11/2024 - 07/11/2024	)	350.00	105.00	245.00
Total ROOM CHARGES					1,400.00	420,00	980,00
UACDITAL ME	EDICAL SERVICES						
	<del></del>	٠			0.004.40	445.00	0.400.04
DRUGS FORM					2,304.10	115.09	2,189.01
	UFACTURED ITEMS				18.25	0.91	17.34
	MEDICAL SERVICE				343.00	34.30	308.70
EQUIPMENT					504.00	50,40	453.60
	RVICES/PROCEDURES				49.00	4.90	44.10
GENERAL SU					216.00	21.57	194,43
HOSPITAL SU LABORATOR					308.00	30.80	277,20
	TORD SERVICES				1,612.10	161.21	1,450.89
MEDICAL RE	-	•			66.00 160.30	0,00	66.00
	LABORATORY				160.00	16.03 0.00	144.27 160.00
NURSING SEI					853.00	85.30	767.70
PACKAGE	(VICES				0.00	0,00	0.00
PPE SUPPLIE	e.				2.40	0.00	2.16
PROCEDURE					396.00	39,60	356.40
Total HOSPITAL MEDICAL				_	6,992.15	560.35	6,431,80
Total HOSPITAL CHARGE				_			
IDIAI NOSPIIAL CHARGE	.3				8,392.15	980.35	7,411.80



## **PATIENT BILL FULL AMOUNT**

FORMAT: SUMMARY

**REF BILL NO** 

: SMC-IP 10093820

VISIT TYPE

: INPATIENT

PATIENT NAME

: DAYALAN A/L SATHIAMUTTY

IC / PASSPORT NO

: 750313025181

MEDICAL RECORD NO

: 1001192649

VISIT ID

: SMC-IP 1228074

ADMISSION DATE AND TIME FINANCIAL TYPE	E : 04/11/2024 . 4:24 PM : PMCARE SDN BHD - PMCARE 2020 (IP)	DIS	CHARGE D	ATE AND TIME	: 08/11/2024	01:00 PM
SERVICE CODE	DESCRIPTION OF SERVICE	DATE	QTY	GROSS AMOUNT <sup>I</sup>	DISCOUNT	ALLOCATED AMOUNT
CONSULTAN	IT(S) FEES	er verland More annine recovers vers vers verbere verhilder verbiligende vig gle				
DR NIK ASM	AH BINTI NIK HUSSAIN (CARDIOLOGY)					
REPORTING	FEES					
230100 100% 803FDR F	SD ECG - RESTING REPORT FEE	04/11/2024	1	80.00	0.00	80.00
		_		80,00	0.00	80.00
DR SITI HAR	NIDA BINTI MD ISA (ENDOCRINOLOGY & DIABETE	S)				
CONSULTAT	ION FEES					
8202C3 100% 025C	FIRST [INPATIENT] CONSULTATION	05/11/2024	1	235.00	0.00	235.00
8202C3 A2 020C	WARD VISIT	06/11/2024	1	95.00	0.00	95,00
8202C3 A3 020C	WARD VISIT	06/11/2024	1	85.00	0.00	85.00
8202C3 100% 020C	WARD VISIT	07/11/2024	1	105.00	0.00	105.00
8202C3 A2 020C	WARD VISIT	08/11/2024	1	95.00	0.00	95.00
		_		615.00	0,00	615,00
<ul> <li>DR VINCENT</li> </ul>	WONG CHUN-WEI (NEPHROLOGY)			510.00	0.00	010,00
CONSULTATI	ION FEES					
8202C3 100% 025C	FIRST [INPATIENT] CONSULTATION	04/11/2024		235.00	0.00	235.00
8202C3 100% 020C	WARD VISIT	04/11/2024	1	105.00	0.00	105.00
8202C3 100% 020C	WARD VISIT	05/11/2024	2	210.00	0.00	210,00
8202C3 100% 020C	WARD VISIT	06/11/2024	2	210.00	0.00	210.00
8202C3 100% 020C	WARD VISIT	07/11/2024	2	210.00	0.00	210.00
8202C3 100% 020C	WARD VISIT	08/11/2024	2	210,00	0.00	210,00
•		_		1,180.00	0.00	1,180.00
				.,	0.00	1,100.00



**FULL AMOUNT** 

FORMAT: SUMMARY

REF BILL NO

: SMC-IP 10093820

VISIT TYPE

: INPATIENT

PATIENT NAME

FINANCIAL TYPE

: DAYALAN A/L SATHIAMUTTY

IC / PASSPORT NO

: 750313025181

MEDICAL RECORD NO

: 1001192649

VISIT ID

: SMC-IP 1228074

: 04/11/2024

DESCRIPTION OF SERVICE

DISCHARGE DATE AND TIME

08/11/2024

01:00 PM

ADMISSION DATE AND TIME

4:24 PM : PMCARE SDN BHD - PMCARE 2020 (IP)

GROSS

DISCOUNT

ALLOCATED **AMOUNT** 

CODE Total CONSULTANT(S) FEES

SERVICE

DATE

QTY AMOUNT 1,875.00

0.00

1,875.00

**GRAND TOTAL** 

10,267.15

980.35

9,286.80

NAZATUL ALIA BINTI ZAINI

Print Date:

08/11/2024

01:10PM

Page 3 of 4



**FULL AMOUNT** 

FORMAT: SUMMARY

REF BILL NO

: SMC-IP 10093820

: INPATIENT

PATIENT NAME

: DAYALAN A/L SATHIAMUTTY

IC / PASSPORT NO

: 750313025181

MEDICAL RECORD NO

:1001192649

: SMC-IP 1228074

ADMISSION DATE AND TIME

VISIT ID

VISIT TYPE

01:00 PM

FINANCIAL TYPE

: 04/11/2024 4:24 PM : PMCARE SDN BHD - PMCARE 2020 (IP)

DISCHARGE DATE AND TIME

08/11/2024

SERVICE CODE					
MARKET STATES SATISFACTOR STATES OF STATES	30098431	0000000	960	11111	_
MARKET STATES SATISFACTOR STATES OF STATES	X0207X0	CX0444	3 C K	VILLE	_
CODE	1/930 v.	1.47. X.		AVALAY.A	
CODE	0.25253	Market	4000000000	212122822	м
	genade.	100000000000000000000000000000000000000	$\sim$	35 896	15.1
	3572385	9337001		. 33.000	s×.

DESCRIPTION OF SERVICE

DATE

GROSS AMOUNT

DISCOUNT

ALLOCATED AMOUNT

Date	Description	Duration	Quantity
08/11/2024	Empagliflozin 25mg Tab (Jardiance)	1 Month(s)	30 Tablet
08/11/2024	Gliclazide MR 60mg Tab (Diamicron MR)	1 Month(s)	30 Tablet
08/11/2024	Janumet XR 50/1000mg Tab (Sita+Met XR)	1 Month(s)	60 Tablet
08/11/2024	Rosuvastatin 20mg Tab (Crestor)	1 Month(s)	60 Tablet

NAZATUL ALIA BINTI ZAINI

Print Date:

08/11/2024

01:10PM

Page 4 of 4



## **PATIENT BILL FULL AMOUNT**

FORMAT: DETAIL BREAK-UP

DAYALAN A/L SATHIAMUTTY,

B-19-13, TREEFALL, SETIA ALAM,

47000,SHAH ALAM,

SELANGOR DARUL EHSAN, MALAYSIA

BILL NO

: SMC-IP 10093820

BILL DATE

: 08/11/2024

PATIENT NAME

: DAYALAN A/L SATHIAMUTTY

IC / PASSPORT NO MEDICAL RECORD NO 750313025181

: 1001192649

VISIT ID

: SMC-IP 1228074

ENCOUNTER TYPE

: INPATIENT

VISIT TYPE

: IP

ADMITTING DOCTOR

: DR VINCENT WONG CHUN-WEI

04:24 PM

ADMISSION DATE & TIME DISCHARGE DATE & TIME : 04/11/2024 : 08/11/2024

01:00 PM

EMPLOYEE NAME

RELATION

EMPLOYEE NO

GL REFERENCE NO

: 24110616141669

CREDIT TERM

: 30,00Days

FINANCIAL TYPE

: PMCARE SDN BHD - PMCARE 2020 (IP)

FINANCIAL TYPE	: PMCARE SDN BHD	- PMCARE 2020 (IP)					
SERVICE CODE	DESCRIPTION OF SERVIC	Andreas de la Company de l En la companya de la	DATE	QTY	GROSS AMOUNT	DISCOUNT	ALLOCA AMOU
OSPITAL CHARGES				e con an dan	pestaural da Cuara		
ROOM CHAR	GES						
ACCOMMOD.	ATION						
1-1040	PREMIER SINGLE	( 04/11/2024	- 04/11/2024 )	1	350,00	105,00	245.0
1-1040	PREMIER SINGLE	( 05/11/2024	- 05/11/2024 )	1	350,00	105,00	245,0
1-1040	PREMIER SINGLE	( 06/11/2024	- 06/11/2024 )	1	350.00	105,00	245.0
1-1040	PREMIER SINGLE	( 07/11/2024	- 07/11/2024 )	1	350,00	105,00	. 245.0
otal ROOM CHARGES			_		1,400.00	420.00	980.0
HOSPITAL MI	EDICAL SERVICES						
DRUGS FOR	MULARY						
4-1671	BD POSIFLUSH (SOD CHL	OR 0.9%) 5ML PFS	04/11/2024	1	31.90	1.59	30.3
4-2214	EMPAGLIFLOZIN 25MG TAI	B (JARDIANCE)	04/11/2024	4	43.80	2.19	41.6
4-2203	GLICLAZIDE MR 60MG TAE	(DIAMICRON MR)	04/11/2024	1	5.25	0.26	4.9
4-876	GLYCERIN THYMOL GARG	LE 120ML	04/11/2024	1	19.05	0.95	18.1
4-2216	JANUMET XR 50/1000MG T	AB (SITA+MET XR)	04/11/2024	8	51.20	2.56	48.6
4-2009	PARACETAMOL 500MG TAI	BLET (PANADOL)	04/11/2024	4	6,60	0.32	6.2
4-651	PROSPAN COUGH SYR 10	OML	04/11/2024	1	33.30	1.66	31.6
4-108	RACECADOTRIL 100MG CA	AP (HIDRASEC)	Ó4/11/2024	0	0.00	0.00	. 0.0
4-1888	ROSUVASTATIN 20MG TAB	(CRESTOR)	04/11/2024	2	26.10	1.30	24.8
4-1262	(!) INSULIN LANTUS SOLO: PEN, 3ML (GLARGINE)	STAR 100 UNITS/ML	05/11/2024	1	157.05	7.85	149.2
4-1671	BD POSIFLUSH (SOD CHL	OR 0.9%) 5ML PFS	05/11/2024	1	31.90	1.59	30.3
4-2203	GLICLAZIDE MR 60MG TAE	(DIAMICRON MR)	05/11/2024	1	5.25	0.26	4.9
4-2009	PARACETAMOL 500MG TAI	BLET (PANADOL)	05/11/2024	8	13.20	0.64	12.5
4-108	RACECADOTRIL 100MG CA	AP (HIDRASEC)	05/11/2024	0	0.00	0.00	0.0
4-1888	ROSUVASTATIN 20MG TAB	(CRESTOR)	05/11/2024	2	26,10	1.30	24,8
4-1671	BD POSIFLUSH (SOD CHLO	DD 0.00() EMI DED	06/11/2024	2	63.80	3.18	60.6

08/11/2024



#### **FULL AMOUNT**

FORMAT: DETAIL BREAK-UP

REF BILL NO

: SMC-IP 10093820

VISIT TYPE

: INPATIENT

PATIENT NAME

: DAYALAN A/L SATHIAMUTTY

IC / PASSPORT NO

: 750313025181

MEDICAL RECORD NO

: 1001192649

VISIT ID

; SMC-IP 1228074

ADMISSION DATE AND TIME

: 04/11/2024 4:24 PM

DISCHARGE DATE AND TIME

08/11/2024

01:00 PM

	121,10					. 01,001 141
FINANCIAL TYPE	: PMCARE SDN BHD - PMCARE 2020 (IP)					
SERVICE CODE	DESCRIPTION OF SERVICE	DATE	QTY	GROSS AMOUNT	DISCOUNT	ALLOCATED AMOUNT
4-2214	EMPAGLIFLOZIN 25MG TAB (JARDIANCE)	06/11/2024	(3)	(32,85)	(1.64)	(31.21)
4-2203	GLICLAZIDE MR 60MG TAB (DIAMICRON MR)	06/11/2024	1	5.25	0.26	4.99
4-2009	PARACETAMOL 500MG TABLET (PANADOL)	06/11/2024	2	3.30	0.16	3.14
4-1888	ROSUVASTATIN 20MG TAB (CRESTOR)	06/11/2024	2	26.10	1.30	24.80
4-1671	BD POSIFLUSH (SOD CHLOR 0.9%) 5ML PFS	07/11/2024	1	31.90	1.59	30.31
4-2203	GLICLAZIDE MR 60MG TAB (DIAMICRON MR)	07/11/2024	1	5.25	0,26	4.99
4-2216	JANUMET XR 50/1000MG TAB (SITA+MET XR)	07/11/2024	8	51.20	2.56	48.64
4-108	RACECADOTRIL 100MG CAP (HIDRASEC)	07/11/2024	2	22.00	1,10	20.90
4-1888	ROSUVASTATIN 20MG TAB (CRESTOR)	07/11/2024	2	26,10	1.30	24.80
4-2214	EMPAGLIFLOZIN 25MG TAB (JARDIANCE)	08/11/2024	30	328.50	16.42	312.08
4-2203	GLICLAZIDE MR 60MG TAB (DIAMICRON MR)	08/11/2024	31	162,75	8,13	154.62
4-2216	JANUMET XR 50/1000MG TAB (SITA+MET XR)	08/11/2024	52	332,80	16.64	316.16
4-651	PROSPAN COUGH SYR 100ML	08/11/2024	1	33.30	1.66	31.64
4-108	RACECADOTRIL 100MG CAP (HIDRASEC)	08/11/2024	1	11.00	0.55	10.45
4-1888	ROSUVASTATIN 20MG TAB (CRESTOR)	08/11/2024	60	783.00	39.15	743.85
DRUGS: M	ANUFACTURED ITEMS					
4-329	INSUPEN NEEDLES 33G, 4MM 20'S	05/11/2024	1	18.25	0.91	17.34
EMERGEN	CY MEDICAL SERVICE					
12-15753	A&E FEE (YELLOW).	04/11/2024	1	94.00	9.40	84.60
12-15778	AE RMO - COVID THROAT SWAB.	04/11/2024	1	0.00	0.00	0.00
12-15787	AE RMO - IV LINE SETTING.	04/11/2024	1	59.00	5,90	53.10
12-15792	AE RMO - PHLEBOTOMY/ BLOOD CULTURE (OBS/WARD).	04/11/2024	1	45.00	4.50	40.50
12-15793	ÀE RMO - PHLEBOTOMY/BLOOD CULTURE,	04/11/2024	1	31.00	3.10	27.90
12-5699	AE ECG RESTING	04/11/2024	1	70.00	7.00	63.00
12-285	AE OBS BAY / HOUR - A&E	04/11/2024	1	44.00	4.40	39.60

05/11/2024

06/11/2024

07/11/2024

08/11/2024

04/11/2024

04/11/2024

04/11/2024

04/11/2024

04/11/2024

04/11/2024

04/11/2024

04/11/2024

3

3

3

3

1

1

1

1

1

1

0

1

126.00

126.00

126,00

126.00

19,00

30.00

12.95

28.95

16.25

12.10

0.00

17.50

12.60

12.60

12 60

12.60

1,90

3.00

1.29

2.89

1.62

1.21

0.00

1.75

STIMWAY MEDICAL	CENTRE SDN BHD 100501012652 /241855 XX
ACHIVVAT WEINGAL	CENTRE 313N DELL 199501012653 (3/1855-Y)

EQ INF PUMP USE / 8HR

NS INJECTION PER USE

3M TEGADERM IV ADVANCED 6.5CM X 7CM

4097154N SAFEFLOW EXTENSION SET

INTRAFIX SAFESET PILS, Y-N.F. VALVE

LATEX EXAMINATION GLOVES POWDER

LATEX EXAMINATION GLOVES POWDER

MEDIAIRE MALE URINAL 875ML, SIZE: 245L X

NS PVL ITEM USED

FREE SIZE M 20S

FREE SIZE S 20S

105W X 125H MM

**GENERAL SERVICES/PROCEDURES** 

No.5, Jalan Lagoon Selatan, Bandar Sunway, 47500 Subang Jaya, Selangor, Malaysia Tel: +603 7491 9191 / 5566 9191 Fax: +603 7491 8181 www.sunwaymedical.com

**EQUIPMENT USAGE** 

**GENERAL SUPPLIES** 

12-1944

12-1944

12-1944

12-1944

12-1992

12-1995

7-121000012

7-164100003

7-135000001

7-102200031

7-102200030

7-141300002

NAZATUL ALIA BINTI ZAINI

Print Date:

08/11/2024

01:10PM

Page 2 of 6

113.40

113.40

113,40

113.40

17,10

27.00

11.66

26.06

14.63

10.89

0.00

15.75



#### **FULL AMOUNT**

FORMAT: DETAIL BREAK-UP

REF BILL NO

: SMC-IP 10093820

VISIT TYPE

: INPATIENT

PATIENT NAME

: DAYALAN A/L SATHIAMUTTY

IC / PASSPORT NO

: 750313025181

MEDICAL RECORD NO

: 1001192649

VISIT ID

: SMC-IP 1228074

ADMISSION DATE AND TIME

: 04/11/2024 4:24 PM

DISCHARGE DATE AND TIME

08/11/2024

01:00 PM

FINANCIAL TYPE	Ē

: PMCARE SDN BHD - PMCARE 2020 (IP)

SERVICE CODE	DESCRIPTION OF SERVICE	DATE	QTY	GROSS AMOUNT	DISCOUNT	ALLOCATED AMOUNT
7-141100001	MS-KD300 MEDIAIRE KIDNEY DISH 700ML, SIZE: 250L X 130W X 50H MM	04/11/2024	1	5,30	0.53	4.77
7-175000008	STRETCHER COVER (DARK BLUE FILM)+PILLOW CASE	04/11/2024	1	91.35	9.13	82.22
7-133000002	VASOFIX SAFETY G20 X 33MM FEP	04/11/2024	1	15.35	1.53	13.82
7-135000001	INTRAFIX SAFESET P I.S. Y-N.F. VALVE	07/11/2024	1	16.25	1.62	14.63
HOSPITAL S	UPPORT FEES					
12-14394	HOSPITAL SUPPORT FEES	04/11/2024	1	77.00	7.70	69.30
12-14394	HOSPITAL SUPPORT FEES	05/11/2024	1	77.00	7.70	69.30
12-14394	HOSPITAL SUPPORT FEES	06/11/2024	1	77,00	7.70	69.30
12-14394	HOSPITAL SUPPORT FEES	07/11/2024	1	77.00	7.70	69.30
LABORATOR	RΥ					
2-75011	ADMISSION PROFILE 1	04/11/2024	1	196.30	19,63	176,67
2-74629	DENGUE IGM/IGG	04/11/2024	1	138,00	13.80	124.20
2-69033	DENGUE NSI ANTIGEN	04/11/2024	1	163.00	16.30	146.70
2-68209	FULL BLOOD COUNT (FBC)	04/11/2024	1	72.00	7.20	64.80
2-69117	GLUCOSE - POCT	04/11/2024	2	62.40	6.24	56.16
2-21271	FERRITIN	05/11/2024	1	121.00	12.10	108.90
2-68209	FULL BLOOD COUNT (FBC)	05/11/2024	1	72,00	7.20	64.80
2-69117	GLUCOSE - POCT .	05/11/2024	4	124.80	12.48	112.32
2-70438	HEMOGLOBIN A1C (HBA1C)	05/11/2024	1	89,00	8.90	80.10
2-67340	LIVER FUNCTION TEST (LFT)	05/11/2024	1	108,00	10.80	97,20
2-68209	FULL BLOOD COUNT (FBC)	06/11/2024	1	72.00	7,20	64,80
2-69117	GLUCOSE - POCT	06/11/2024	4	124.80	12.48	112.32
2-68209	FULL BLOOD COUNT (FBC)	07/11/2024	1	72.00	7.20	64.80
2-69117	GLUCOSE - POCT	07/11/2024	3	93.60	9.36	84.24
2-68209	FULL BLOOD COUNT (FBC)	08/11/2024	1	72,00	7.20	64.80
2-69117	GLUCOSE - POCT	08/11/2024	1	31.20	3,12	28.08
	CORD SERVICES	OCT TILDET	'	01.20	0,12	20.00
12-2400	ADMISSION FEE	04/11/2024	1	66.00	0.00	66,00
MEDICAL SU		0-11 T17202-7	•	00,00	0.00	33.50
4-1049	SODIUM CHLORIDE 0.9% 10ML 3613291	04/11/2024	2	7.70	0.77	6.93
4-1041	SODIUM CHLORIDE 0.9% 500ML 3615482	04/11/2024	3	32.70	3.27	29,43
4-1041	SODIUM CHLORIDE 0.9% 500ML 3615482	05/11/2024	3	32,70	3.27	29.43
4-1041	SODIUM CHLORIDE 0.9% 500ML 3615482	06/11/2024	3	32.70	3.27	29.43
4-1041	SODIUM CHLORIDE 0.9% 500ML 3615482	07/11/2024	4	43.60	4.36	39.24
4-1041	SODIUM CHLORIDE 0.9% 500ML 3615482	08/11/2024	1	10.90	1.09	9.81
	LABORATORY	00/11/2024	•	10.50	1.03	9.61
2-75093	SARS-COV-2 RT-PCR (COVID-19)	04/11/2024	1	160.00	0.00	160.00
NURSING SE	· · ·	04/11/2024	'	100.00	0.00	100.00
12-2692	AE NURSING PROCEDURE CHARGES	04/11/2024	1	13.00	1.30	11 70
12-2707	NS NURSING SERVICE FEES	04/11/2024	1	198.00	1,30	11,70
12-2707	NS NURSING SERVICE FEES	05/11/2024	1	198.00	19.80	178.20
,_ 2,0,	TO TOTAL OF THE PERSON OF THE		ı	150,00	19,00	178.20

## SUNWAY MEDICAL CENTRE SDN BHD 199501012853 (341855-X)

No.5, Jalan Lagoon Selatan, Bandar Sunway, 47500 Subang Jaya, Selangor, Malaysia Tel: +603 7491 9191 / 5566 9191 Fax: +603 7491 8181 www.sunwaymedical.com



#### **FULL AMOUNT**

FORMAT: DETAIL BREAK-UP

REF BILL NO

: SMC-IP 10093820

VISIT TYPE

: INPATIENT

PATIENT NAME

: DAYALAN A/L SATHIAMUTTY

IC / PASSPORT NO

: 750313025181

MEDICAL RECORD NO

: 1001192649

VISIT ID

: SMC-IP 1228074

ADMISSION DATE AND TIME

: 04/11/2024 4:24 PM

DISCHARGE DATE AND TIME

08/11/2024

01:00 PM

12-2707 N 12-2707 N 12-5700 A PACKAGE 8-827 ( PPE SUPPLIES 7-102100034 S 7-102100033 S	: PMCARE SDN BHD - PMCARE 2020 (IP)  DESCRIPTION OF SERVICE  US NURSING SERVICE FEES US NURSING SERVICE FEES US NURSING SERVICE FEES US ECG NURSING ELECTRODE  COVID ANTIGEN TEST - FREE OF CHARGE UP-FOC)  N' NITRILE POWDERED FREE EXAM GLOVE	06/11/2024 07/11/2024 07/11/2024 04/11/2024	QTY 1 1 2	GROSS AMOUNT 198,00 198,00 48.00	19.80 19.80	-ALLOCATED AMOUNT 178.20 178.20
12-2707 N 12-2707 N 12-5700 A PACKAGE 8-827 ( PPE SUPPLIES 7-102100034 S 7-102100033 S	NS NURSING SERVICE FEES NS NURSING SERVICE FEES NE ECG NURSING ELECTRODE COVID ANTIGEN TEST - FREE OF CHARGE IP-FOC)	06/11/2024 07/11/2024 04/11/2024	1 1 2	AMOUNT 198,00 198,00	19.80 19.80	AMOUNT
12-2707 N 12-5700 A PACKAGE 8-827 ( PPE SUPPLIES 7-102100034 9 57-102100033 9	NS NURSING SERVICE FEES AE ECG NURSING ELECTRODE COVID ANTIGEN TEST - FREE OF CHARGE IP-FOC)	07/11/2024 04/11/2024	1 2	198,00	19.80	
12-5700 A PACKAGE 8-827 ( PPE SUPPLIES 7-102100034 9 57-102100033 9	AE ECG NURSING ELECTRODE COVID ANTIGEN TEST - FREE OF CHARGE IP-FOC)	04/11/2024	2			178,20
PACKAGE 8-827 ( PPE SUPPLIES 7-102100034 ( 57-102100033 ( 68-68-68-68-68-68-68-68-68-68-68-68-68-6	COVID ANTIGEN TEST - FREE OF CHARGE IP-FOC)			48.00	4.90	
8-827 ( PPE SUPPLIES  7-102100034 9  7-102100033 9	IP-FOC)	04/11/2024			4.80	43.20
PPE SUPPLIES 7-102100034 9 8 7-102100033 9	IP-FOC)	04/11/2024				
7-102100034 9 8 7-102100033 9	" NITRILE POWDERED FREE EXAM GLOVE		1	0.00	0.00	0.00
7-102100033 S	INTRILE POWDERED FREE EXAM GLOVE	0.4144/0.004	_	4.00	0.40	
7-102100033 9	SIZE M 100S	04/11/2024	2	1.20	0.12	1.08
	" NITRILE POWDERED FREE EXAM GLOVE SIZE S 100S	04/11/2024	2	1,20	0.12	1,08
PROCEDURES						
12-1947 N	NS MONITORING PACKG / 8HR	04/11/2024	1	99.00	9.90	89.10
12-1947 N	NS MONITORING PACKG / 8HR	05/11/2024	1	99.00	9,90	89.10
12-1947 N	IS MONITORING PACKG / 8HR	06/11/2024	1	99.00	9.90	89.10
12-1947 N	IS MONITORING PACKG / 8HR	07/11/2024	1	99.00	9.90	89.10
Total HOSPITAL MEDICAL S	ERVICES			6,992.15	560.35	6,431.80
Total HOSPITAL CHARGES		-		8,392.15	980.35	7,411.80
CONSULTANT(S	) FEES					
DR NIK ASMAH I	BINTI NIK HUSSAIN (CARDIOLOGY)					
REPORTING FEE	ES					
230100 100% 803FDR F	SD ECG - RESTING REPORT FEE	04/11/2024	1	80,00	0.00	80.00
		_		80.00	0.00	80.00
DR SITI HARNID.	A BINTI MD ISA (ENDOCRINOLOGY & DIABETES	S )		80.00	0.00	00.00
CONSULTATION		•				•
	FIRST [INPATIENT] CONSULTATION	05/11/2024	1	235,00	0.00	235,00
8202C3 A2 020C	WARD VISIT	06/11/2024	1	95.00	0.00	95.00
8202C3 A3 020C	WARD VISIT	06/11/2024	1	85.00	00,0	85.00
8202C3 100% 020C	WARD VISIT	07/11/2024	1	105.00	0.00	105.00
8202C3 A2 020C	WARD VISIT	08/11/2024	1	95.00	0.00	95.00
				615.00	0,00	615.00

### SUNWAY MEDICAL CENTRE SDN BHD 199501012653 (341855-X)

NAZATUL ALIA BINTI ZAINI

Print Date:

08/11/2024

01:10PM

Page 4 of 6



#### **FULL AMOUNT**

FORMAT: DETAIL BREAK-UP

REF BILL NO

: SMC-IP 10093820

VISIT TYPE

: INPATIENT

PATIENT NAME

: DAYALAN A/L SATHIAMUTTY

IC / PASSPORT NO

: 750313025181

MEDICAL RECORD NO

: 1001192649

VISIT ID

: SMC-IP 1228074

ADMISSION DATE AND TIME

: 04/11/2024 4:24 PM

DISCHARGE DATE AND TIME

08/11/2024

01:00 PM

FINANCIAL TYPE		: PMCARE SDN BHD - PMCARE 2020 (IP)					
SERVI CODE	23(23(20g22c:254cxcf4)	DESCRIPTION OF SERVICE	DATE	QTY	GROSS AMOUNT	DISCOUNT	ALLOCATED AMOUNT
● DR V	INCENT	WONG CHUN-WEI (NEPHROLOGY)				(the state of the constraint space	
CON	SULTATIO	ON FEES					
8202C3 025C	100%	FIRST [INPATIENT] CONSULTATION	04/11/2024	1	235,00	0.00	235.00
8202C3 020C	100%	WARD VISIT	04/11/2024	1	105.00	0.00	105.00
8202C3 020C	100%	WARD VISIT	05/11/2024	2	210.00	0.00	210.00
8202C3 020C	100%	WARD VISIT	06/11/2024	2	210.00	0,00	210.00
8202C3 020C	100%	WARD VISIT	07/11/2024	2	210.00	0.00	210.00
8202C3 020C	100%	WARD VISIT	08/11/2024	2	210.00	0.00	210.00
			-		1,180.00	0.00	1,180.00
Total CONSULTA	NT(S) FE	ES	_		1,875,00	0.00	1,875.00
GRAND TOTAL					10,267.15	980.35	9,286.80

08/11/2024



Req. date : 04/11/2024 02:42 PM

Coll. date : 04/11/2024 03:06 PM Request No : 4500992053 URGENT

: 0001227483 Hos No

Doctor : DR ANG JIEYANG Location : A&E Clinic

Req. comment: Pat. comment: Molecular

Name : DAYALAN A L SATHLAMUTTY

Pat No : 1001192649 Hos No: 0001228074 Alt No : 00750313025181 D.O.B.: 13/03/1975

Sex ; Male

#### COVID-19 RT-PCR

Specimen Type SARS-CoV-2

Nasopharyngeal and oropharyngeal swabs

Not detected

Reference range: Ct > 40 Not Detected (Negative) Reference range Ct < 40 Detected (Positive)

#### Methodology:

This test was performed using multiplex real-time RT-PCR assay for the detection of SARS-CoV-2 (COVID-19). The detection limit of this assay is within 100 copies/mL to 500 copies/mL. Thus, a negative PCR does not exclude the presence of pathogens present which may be in numbers below the detection limit of the assay or may be due to pathogens that are not in the list of test panel.

If the individual risk (eg. travel, contact with case etc) is within the incubation period of 14 days, it is advisable to retest at the end of the incubation period.

Ref: Guidelines COVID-19 Management in Malaysia No. 05/2020 (Edisi Kelima) Dated 25 March 2020

<sup>\*</sup> The above test is accredited under scope of accreditation MS ISO 15189

Req. date : 04/11/2024 02:41 PM

Coll. date : 04/11/2024 03:07 PM Request No : 4500992050 URGENT

: 0001227483 Hos No Doctor : DR ANG ЛЕYANG

Location : A&E Clinic

Req. comment: Pat. comment: Immunosero

Dengue Antibody
Dengue IgM
Dengue IgG
Dengue Antigen

Name : DAYALAN A L SATHLAMUTTY

Pat No : 1001192649 Hos No: 0001228074 Alt No : 00750313025181 D.O.B.: 13/03/1975

Sex ; Male

Negative Negative Negative

Sex : Male

Req. date : 04/11/2024 02:41 PM Name : DAYALAN A L SATHIAMUTTY

Coll. date : 04/11/2024 03:08 PM Pat No : 1001192649 Request No : 4500992049 URGENT Hos No: 0001228074 Alt No : 00750313025181 Hos No : 0001227483 Doctor : DR ANG JIEYANG
Location : A&E Clinic D.O.B.: 13/03/1975

Req. comment: Pat. comment: Haemato

## Full Blood Count

run Bioon Count				
RBC		4,86	10^12/L	4.50 - 5.50
· Haemoglobin		14.3	g/dL	13.0 - 17.0
PCV		41	%	40 - 50
MCV		84	fL	80 - 99
MCH		29	pg	27 - 32
MCHC	Н	35.0	g/dL	31.5 - 34.5
RDW		12.8	- <sub>%</sub>	11.6 - 14.0
Platelet Count		168	10^9/L	150 - 410
Total WBC		6.1	10^9/L	4.0 - 10.0
Differential Count				
Neutrophil		54	%	40 - 75
Lymphocytes		36	<b>%</b>	20 - 45
Monocytes		6	%	2 - 10
Eosinophils		3	%	0 - 6
Basophils		1	%	0 - 2
Neutrophil #		3.29	K/uL	2.00 - 7.00
Lymphocytes #		2.20	K/uL	1.00 - 3.00
Monocytes #		0.37	K/uL	0.20 - 1.00
Eosinophils #		0.18	K/uL	0.02 - 0.50
Basophils #		0.06	K/uL	0.02 - 0.10

DC (Manual)

Reg. date : 04/11/2024 03:08 PM Coll. date : 04/11/2024 04:05 PM

Request No : 4500992200 Hos No : 0001227483 Doctor : DR ANG JIEYANG
Location : A&E Clinic

Req. comment: Pat. comment: Chemistry

Name : DAYALAN A L SATHIAMUTTY

Pat No : 1001192649 Hos No: 0001228074 Alt No : 00750313025181 D.O.B.: 13/03/1975 Sex : Male

Renal	Profile	1
-------	---------	---

Renal Profile 1				
Sample condition		Lipemic +, leteric +		
Sodium		136	mmol/L	136 - 145
Potassium		3.8	mmol/L	3.5 - 5.1
Chloride		99	mmol/L	98 - 107
Glucose	Н	22.0	mmol/L	3.9 - 6.0
Urea		3.5	mmol/L	3.2 - 7.4
Creatinine	L	60	umol/L	64 - 104
eGFR		>90		
eGFR Interpretation: Normal or high kidney function.				
Uric Acid		294	umol/L	210 - 420
Albumin		43	g/L	35 - 52
Calcium		2.27	mmol/L	2.10 - 2.55
Corrected Calcium		2.21	mmol/L	2.10 - 2.55
Phosphate Inorganic		1.08	mmol/L	0.74 - 1.52
LFT				
Protein total		76	g/L	64 - 83
Albumin		43	g/L	35 - 52
Globulin		33	g/L	20 - 40
A/G Ratio		1.3		
Bilirubin Total	H	24.4	umol/L	3.4 - 20.5
ALP		90	U/L	50 - 116
ALT		27	U/L	0 - 55
AST		20	U/L	<b>5 - 34</b>
Gamma - GT	Н	123	U/L	12 - 64
Immunosero			_	
C-Reactive Protein		1.3	nig/L	< 5.0

Req. date

: 04/11/2024 03:08 PM

Coll. date : 04/11/2024 04:36 PM Request No : 4500992244

Hos No

: 0001227483

Doctor

: DR ANG JIEYANG

Location

: A&E Clinic

Req. comment: Pat. comment: Urinalysis

Name : DAYALAN A L SATHIAMUTTY

1.000 - 1.030

4.2 - 8.4

< 2.0

< 7 < 6

mg/dL

cells/uL

cells/uL

Pat No : 1001192649

Hos No: 0001228074 Alt No : 00750313025181 D.O.B.: 13/03/1975

Sex : Male

Urinalysis

Appearance Color Glucose

Bilirubin Ketone

Specific Gravity Reaction-pH Protein Urobilinogen

Nitrite Blood Leucocytes

Microscopy

RBC (URINE)
WBC
Epithelial Cells Crystal Hyaline Cast

Pathological Cast Bacteria Mucous Thread Yeast

Clear Light Yellow

4+ Negative Negative 1.032

H 6.0 Negative <2.0 Negative

Negative Negative

1 Nil

Nil Nil Nil Nil Nil Nil



Req. date : 04/11/2024 03:13 PM Coll. date : 05/11/2024 06:18 AM

Request No : 4500992925 Hos No : 0001228074

Doctor : VINCENT WONG CHUN-WEI

Location : WARD 2C

Req. comment:
Pat. comment:
Chemistry

Name : DAYALAN A L SATHIAMUTTY

Pat No : 1001192649 Hos No : 0001228074 Alt No : 00750313025181 D.O.B. : 13/03/1975

Sex : Male

10.0 % 86 mmol/mol

HBA1C

Haemoglobin Alc IFCC HbAlc

Methodology: Enzymatic

Diagnostic Values of HbA1c in Malaysian Adults

HbA1c (NGSP) % HbA1c (IFCC) mmol/mol <5.7 < 39 Normal 5.7 - 6.2 39 - 44 \*Prediabetes (IFG or IGT) >= 6.3 >= 45 T2DM

IFG: Impaired Fasting Glucose; IGT: Impaired Glucose Tolerance; OGTT: Oral Glucose Tolerance Test; T2DM: Type 2 Diabetes Mellitus

\* Recommend OGTT for HbA1c levels 5.7 - 6.2%

Individualised HbA1c Target for Known Diabetes

HbA1c (NGSP) % HbA1c (IFCC) mmol/mol <= 6.5 <= 48 A; Tight target range for young, newly diagnosed diabetes without hypoglycaemia.
6.6 - 7.0 49 - 53 B; Target range for all other individuals not in category A or C.
7.1 - 8.0 54 - 64 C; Target range for diabetes and comorbidities, short life expectancy and/or prone to hypoglycaemia.

Source: 2020 Clinical Practice Guidelines for the Management of Type 2 Diabetes Mellitus (6th Edition). Kuala Lumpur: Joint Publication of the Ministry of Health Malaysia, Academy of Medicine Malaysia, Malaysian Endocrine & Metabolic Society and Diabetes Malaysia.

Req. date : 04/11/2024 03:13 PM

Coll. date : 05/11/2024 06:16 AM

Request No : 4500992927 Hos No : 0001228074

Doctor : VINCENT WONG CHUN-WEI

: WARD 2C Location

Req. comment: Pat. comment:

Name : DAYALAN A L SATHIAMUTTY

Pat No : 1001192649 Hos No: 0001228074 Alt No : 00750313025181 D.O.B.: 13/03/1975

Sex : Male

Chemistry

Ferritin

LFT
Protein total
Albumin
Globulin
A/G Ratio
Bilirubin Total
ALP
ALT
AST
Gamma - GT

L	62	g/L	64 - 83
	37	g/L	35 - 52
	25	g/L	20 - 40
	1.5		
Н	28.7	umol/L	3.4 - 20.5
	70	U/L	50 - 116
	21	U/L	0 - 55
	17	U/L	5 - 34
H	101	U/L	12 - 64
	74.8	ng/mL	21.8 - 274.7

Req. date : 04/11/2024 03:13 PM Coll. date : 05/11/2024 06:17 AM

Request No : 4500992926 Hos No : 0001228074

Doctor : VINCENT WONG CHUN-WEI Location : WARD 2C

Req. comment:

Name : DAYALAN A L SATHIAMUTTY

Pat No : 1001192649 Hos No: 0001228074 Alt No : 00750313025181 D.O.B.: 13/03/1975

Sex : Male

Pat. comment: Haemato

F	uli	Blood	Count

5.03	10^12/L	4.50 - 5.50
14.5	g/dL	13.0 - 17.0
40	%	40 - 50
80	fL	80 - 99
29	pg	27 - 32
36.0		31,5 - 34.5
12.8	_%	11.6 - 14.0
161	10^9/L	150 - 410
6.8	10^9/L	4.0 - 10.0
45	%	40 - 75
41	%	20 - 45
9	%	2 - 10
5	%	0 - 6
1	%	0 - 2
3.06	K/uL -	2.00 - 7.00
2.79	K/uL	1,00 - 3,00
0.61	K/uL	0.20 - 1.00
0.34	K/uL	0.02 - 0.50
0.07	K/uL	0.02 - 0.10
	14.5 40 80 29 36.0 12.8 161 6.8 45 41 9 5 1 3.06 2.79 0.61 0.34	14.5 g/dL 40 % 80 ft. 29 pg 36.0 g/dL 12.8 % 161 10^9/L 6.8 10^9/L  45 % 41 % 9 % 5 % 1 % 3.06 K/uL 2.79 K/uL 0.61 K/uL 0.34 K/uL

DC (Manual)

Req. date

: 04/11/2024 03:13 PM

Coll. date Request No : 05/11/2024 06:18 AM

Hos No

: 4500992925 : 0001228074

Doctor

: VINCENT WONG CHUN-WEI

Location

: WARD 2C

Req. comment: Pat. comment:

Chemistry

HBA1C

Haemoglobin A1c IFCC HbA1c Name : DAYALAN A L SATHIAMUTTY

Pat No: 1001192649 Hos No: 0001228074

Alt No : 00750313025181 D.O.B. : 13/03/1975

Sex : Male

10.0 86 % mmol/mol

Methodology: Enzymatic

Diagnostic Values of HbA1c in Malaysian Adults

HbA1c (NGSP) % HbA1c (IFCC) mmol/mol < 5.7 < 39 Normal 5.7 - 6.2 39 - 44 \*Prediabetes (IFG or IGT) >= 6.3 >= 45 T2DM

IFG: Impaired Fasting Glucose; IGT: Impaired Glucose Tolerance; OGTT: Oral Glucose Tolerance Test; T2DM: Type 2 Diabetes Mellitus

\* Recommend OGTT for HbA1c levels 5.7 - 6.2%

Individualised HbA1c Target for Known Diabetes

HbA1c (NGSP) % HbA1c (IFCC) mmol/mol <=6.5<=48 A: Tight target range for young, newly diagnosed diabetes without hypoglycaemia. 6.6-7.0 49 - 53 B: Target range for all other individuals not in category A or C. 7.1-8.0 54 - 64 C: Target range for diabetes and comorbidities, short life expectancy and/or prone to hypoglycaemia.

Source: 2020 Clinical Practice Guidelines for the Management of Type 2 Diabetes Mellitus (6th Edition). Kuala Lumpur: Joint Publication of the Ministry of Health Malaysia, Academy of Medicine Malaysia, Malaysian Endocrine & Metabolic Society and Diabetes Malaysia.

Req. date : 05/11/2024 12:22 PM Coll. date : 06/11/2024 07:25 AM

Coll. date : 06/11/2024 0'
Request No : 4500996251
Hos No : 0001228074

Doctor : VINCENT WONG CHUN-WEI

Location : WARD 2C

Req. comment:
Pat. comment:
Haemato

Name : DAYALAN A L SATHIAMUTTY

Pat No : 1001192649 Hos No : 0001228074 Alt No : 00750313025181 D.O.B. : 13/03/1975

Sex : Male

run produ Count				
RBC		4.80	10^12/L	4.50 - 5.50
Haemoglobin		13.9	g/dL	13.0 - 17.0
PCV		40	%	40 - 50
MCV		83	fL	80 - 99
MCH		29	pg	27 - 32
MCHC	Н	34.8	g/dL	31.5 - 34.5
RDW		12.9	%	11.6 - 14.0
Platelet Count		150	10^9/L	150 - 410
Total WBC		5.6	10^9/L	4.0 - 10.0
Differential Count				
Neutrophil		60	%	40 - 75
Lymphocytes		29	%	20 - 45
Monocytes		8	%	2 - 10
Eosinophils		3	%	0 - 6
Basophils		1	%	0 - 2
Neutrophil #		3.36	K/uL	2.00 - 7.00
Lymphocytes #		1.62	K/uL	1.00 - 3.00
Monocytes #		0.45	K/uL	0.20 - 1.00
Eosinophils #		0.17	K/uL	0.02 - 0.50
Basophils #		0.06	. K/uL	0.02 - 0.10

DC (Manual)

Req. date : 06/11/2024 11:41 AM : 07/11/2024 07:00 AM

Coll. date Request No : 4500999214

Hos No : 0001228074 : VINCENT WONG CHUN-WEI Doctor

Location : WARD 2C

Req. comment: Pat. comment: Haemato

Name: DAYALAN A L SATHIAMUTTY

Pat No : 1001192649 Hos No: 0001228074 Alt No : 00750313025181 D.O.B.: 13/03/1975

Sex : Male

Full	Blood	Count
------	-------	-------

Full Blood Count			
RBC	4.88	10^12/L	4.50 - 5.50
Haemoglobin	14.3	g/dL	13.0 - 17.0
PCV	41	%	40 - 50
MCV	85	fL	80 - 99
MCH	29	pg	27 - 32
MCHC	H 34.6	g/dL	31.5 - 34.5
RDW	12.9	%	11.6 - 14.0
Platelet Count	156	10^9/L	150 - 410
Total WBC	6.3	10^9/L	4.0 - 10.0
Differential Count			
Neutrophil	59	%	40 - 75
Lymphocytes	28	%	20 - 45
Monocytes	8	%	2 - 10
Eosinophils	5	%	0 - 6
Basophils	1	%	0 - 2
Neutrophil #	3.72	K/uL	2.00 - 7.00
Lymphocytes #	1.76	K/uL	1.00 - 3.00
Monocytes #	0.50	K/uL	0.20 - 1.00
Eosinophils #	0.31	K/uL	0.02 - 0.50
Basophils #	0.06	K/uL	0.02 - 0.10

DC (Manual)

Req. date : 07/11/2024 12:44 PM Name : DAYALAN A L SATHIAMUTTY

Coll, date : 08/11/2024 06:33 AM Request No : 4501002232

Pat No : 1001192649 Hos No: 0001228074

Hos No : 0001228074

Alt No : 00750313025181 D.O.B.: 13/03/1975

Doctor : VINCENT WONG CHUN-WEI Location : WARD 2C

Sex : Male

Req. comment: Pat. comment: Haemato

Full Blood Count			
RBC	5.23	10^12/L	4.50 - 5.50
Haemoglobin	15.1	g/dL	13.0 - 17.0
PCV	44	%	40 - 50
MCV	84	fL	80 - 99
MCH	29	pg	27 - 32
MCHC	34.2	g/dL	31.5 - 34.5
RDW	13.0	%	11.6 - 14.0
Platelet Count	160	10^9/L	150 - 410
Total WBC	7.4	10^9/L	4.0 - 10.0
Differential Count			
Neutrophil	58	%	40 - 75
Lymphocytes	29	%	20 - 45
Monocytes	8 .	%	2 - 10
Eosinophils	4	%	0 - 6
Basophils	1	%	0 - 2
Neutrophil #	4.29	K/uL	2.00 - 7.00
Lymphocytes #	2.15	K/uL	1.00 - 3.00
Monocytes #	0.59	K/uL	0.20 - 1.00
Eosinophils #	0.30	K/uL	0.02 - 0.50
Basophils #	0.07	K/uL	0.02 - 0.10

DC (Manual)

(54 Veals) PR interval	160 ms	Sunway Medical Centre
	436/483 ms	
P-R-Taxes		001193341
	The state of the s	986
Technician ID: FATIMAH	SR Letters of axis.	
	(	Dr Koay Cheng Boon
	Timetral III	
	Referred By: DR MIKIASWAH	Onconfirmed
And the state of t		
		Dr Nik Asmah Nik Hussain
		MMC Full Registration No. 390 rB.
		Consultant Cardiologist
S		VSUNWAY MEDICALCENTRE SDIVBHP
		X2001 X200 X2X
3/6	Comments and the second	
	***************************************	4.99
		The state of the s
105QHZ ZH_0 <del>b</del> -95:0	50,Hz	nythm ld Page Tori