Tenaga Nasional Berhad (200866-W)
Aras 9, Bangunan Warisan TNB,
No. 129 Jalan Bangsar,
59200 Kuala Lumpur

Tel: 1300-80-5656
Fax: 1300-22-5656
General Enquiry: tnbhealthcare@tnb.com.my
GL Request: gl@tnb.com.my

PRE-ADMISSION FORM / BORANG PRA-KEMASUKAN WAD

Private and Confidential/Sulit dan Persendirian

Part 1 (To be completed by patient)
Bahagian 1 *(Untuk diisi oleh Pesakit)*

1. Patient Name: *Nama Pesakit* Nagammal A/P M govindan	2. NRIC (Old & New): *K.P. (Lama & Baru)* 540721085858
3. a. Date of Birth: *Tarikh lahir* 21-07-1954 b. Age: *Umur* 71 c. Sex: *Jantina*	☐Male *Laki-laki* ☑Female *Perempuan*
4. Employee/ Retiree Name: *Nama. Pekerja/Pesara:*	5. Employee No: *No. Pekerja:*
6. Admission / Planned Admission Date: *Tarikh kemasukan hospital* 09/08/2025	
7. Hospital Name: *Nama Hospital* ASSUNTA HOSPITAL	8. Name of Attending Doctor/ Speciality: *Nama Doktor yang merawat/ kepakaran:* Dato Sri Dr. Sunish Nair Lachmanan

Admission Reason / Sebab Kemasukan. *Please tick (✓) and answer accordingly / Sila tanda (✓) dan jawab soalan yang berkenaan*

9. ☐ Accident *Kemalangan*	a. Occurred on: *Berlaku pada* Date ____/____/____ *Tarikh* Time _____ *Masa* ☐ am *pagi* ☐ pm *petang* b. Details of Accident: *Butir-butir kemalangan*
10. ☐ Illness *Penyakit*	a. Symptoms first appeared on: *Tarikh simptom tersebut bermula* Date ____/____/____ *Tarikh* b. Doctor(s) consulted for this condition: *Doktor-doktor yang dilawati bagi penyakit ini* c. Doctor's or Clinic Contact(Address & Telephone): *Alamat & Telefon Doktor*

Declaration and authorization

I declare that the answers given above are true and complete to the best of my knowledge and belief. I understand the delivery of this form is in no way an admission of TNB liability and payment to the hospital by TNB or its representative shall not be construed as final admission of TNB's liability and for this and any further claims arising, TNB reserves all rights for evaluation as appropriate. I am fully aware of the limits as to my medical benefit coverage under the above-mentioned benefit plan. I hereby undertake to settle/reimburse any medical expenses exceeding my entitlement under the said medical benefit plan, or that is not covered by the same. 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 condition, the TNB shall absolutely forfeit my right to compensation and further reserves the right to recover any amounts paid earlier as a result thereof.

I hereby consent for TNB to process my personal data including my sensitive personal data in accordance with the Personal Data Protection Act 2010, its subsidiary legislation and applicable personal data protection code of practice. In furtherance to the consent, I hereby authorize any party including any medical practitioner, medical institution, hospital, insurance company, company or individual, that has any record or knowledge of my medical information including and not limited to medical reports, medical records, background or medical history, treatment, advice or, other personal information or details of my medical condition, mental condition, physical condition and/ or related accident/injury, to disclose such information to TNB or its representative for the purpose of administration and execution of my employment contract with TNB including to obtain the medical benefit from TNB, as well as for other purpose(s) which is permissible under the laws. I also agree that TNB or its representative to use or disclose any of the information collected or held to third parties in relation to any of the above purpose(s). This consent and authorization shall bind my successors and beneficiaries and remain valid notwithstanding my death and/or incapacity in so far as legally possible. I also agree that my consent and authorization on a copy of this form is valid and binding as the original copy.

Pengisytiharan dan pemberikuasa

Saya memahami bahawa penyerahan borang ini, tidak sama sekali boleh dianggap sebagai pengakuan liabiliti TNB ke atas tuntutan saya dan saya bersetuju bahawa bayaran kepada hospital oleh TNB atau wakilnya tidak akan ditafsirkan sebagai pengakuan muktamad liabiliti TNB, dan TNB berhak menjalankan penilaian sewajarnya berhubung tuntutan ini atau apa-apa tuntutan yang timbul selanjutnya. Saya memahami sepenuhnya had-had kemudahan perubatan saya di bawah pelan yang tersebut di atas. Saya dengan ini berjanji akan menyelesaikan sebarang a maun yang melebihi had kelayakan saya, yang tidak dilindungi oleh kemudahan perubatan berkenaan. Saya bersetuju sekiranya saya membuat pengakuan palsu atau tidak mendedahkan maklumat yang berkaitan, TNB berhak membatalkan tuntutan saya dan menarik balik sebarang tuntutan awal yang telah dibayar.

Saya dengan ini memberikan persetujuan kepada TNB untuk memproses data peribadi saya termasuk data peribadi sensitif saya selaras dengan Akta Perlindungan Data Peribadi 2010, perundangan subsidiarinya dan tataamalan perlindungan data peribadi yang terpakai. Lanjutan daripada persetujuan tersebut, saya dengan ini membenarkan mana-mana pihak termasuk mana-mana pengamal perubatan, institusi perubatan, hospital, syarikat insurans, syarikat atau individu, yang mempunyai sebarang rekod atau pengetahuan tentang maklumat perubatan saya termasuk dan tidak terhad kepada laporan perubatan, rekod perubatan, latar belakang atau sejarah perubatan, rawatan, nasihat atau maklumat peribadi lain atau butiran keadaan perubatan, keadaan mental, keadaan fizikal saya dan/ atau kemalangan/kecederaan yang berkaitan, untuk mendedahkan maklumat tersebut kepada TNB atau wakilnya bagi tujuan pentadbiran dan pelaksanaan kontrak pekerjaan saya dengan TNB termasuk untuk mendapatkan faedah perubatan daripada TNB, serta untuk tujuan mana-mana hal yang sah di sisi undang-undang. Saya juga bersetuju untuk TNB atau wakilnya menggunakan atau mendedahkan sebarang maklumat yang dikumpul atau dipegang kepada pihak ketiga yang berkaitan bagi mana-mana tujuan di atas. Persetujuan dan kebenaran ini adalah mengikat waris-waris dan benefisiari saya, dan kekal sah meskipun saya telah meninggal dunia dan/atau tidak berupaya setakat yang dibenarkan di sisi undang-undang. Saya juga bersetuju bahawa persetujuan dan kebenaran saya pada salinan borang ini adalah sah dan mengikat sebagaimana salinan asal.

Signature of Patient/ Guardian /*Tandatangan Pesakit/ Penjaga* 9/8/25 Full Name/*Nama Penuh:* Ravi Kumar IC No./*No. KP:* Date/*Tarikh:* Contact No / *No Telephone:* 6019-04-5543	Signature of Employee/ Retiree / *Tandatangan Pekerja / Pesara* Full Name/*Nama Penuh*: IC No./*No. KP*: Date/*Tarikh*: Contact No / *No Telefon*: Relationship to Patient/ *Hubungan dengan Pesakit:*

NOTE: COMPLETION OF THIS PRE-ADMISSION FORM DOES NOT GUARANTEE THE ISSUANCE OF GUARANTEE LETTER.
NOTA: Melengkapkan borang Pra-Kemasukan Wad ini tidak semestinya menjamin bahawa Surat Jaminan akan dikeluarkan.

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Part 2 ADMISSION SECTION ***(To be completed upon admission by Doctor)***

1.a. Patient name: naggammal b. NRIC: 560721085858 c. Age: d. Sex: ☐ Male ☑ Female

2. Admission No. / MRN: 00303562

3. Hospital Contact and Fax No:

4. Admission Date and Time: 9/8/25

5. Expected days of stay / Discharge Date: few

6. a. Symptoms / Conditions requiring admission: abdominal pain / indigestion / altered bowel / heartburn / chills

b. How long is patient aware of the condition: 2/52

c. Patient's BP/ Temp/ Pulse:

d. Date symptoms first appeared: ____/____/____ 2/52 e. Date first consulted: 09/08/2025

7. a. Any previous consultation / treatment / hospitalization for this symptom / illness or related conditions, or other disorders whether in this hospital Or any other facilities? ☐ **Yes** ☐ **No.** —

b. Was this 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: —

Date | Disease / Disorder | Details of Treatment / Hospitalization | Doctor / Hospital/ Clinic

—

d. Can the condition be managed under the Outpatient basis: ☐ **Yes** ☑ **No.** If no, please provide reasons of admission: sepsis / chest infection

e. Is this medical condition an EMERGENCY condition ☑ **Yes** ☐ **No**

8. a. ☐Admitting Diagnosis: b. ☑ Provisional Diagnosis LRTI / sepsis / dyspepsia GERD / ca.

c. Diagnosis confirmed on ____/____/____ or Advised patient on ____/____/____________

d. Cause and pathology underlying the present diagnosis: infective

e. Any possibility of relapse? ☐Yes ☑No

9. Estimated Total Costs: RM 10,000 excl. BM

10a. Admission requires:	11. Is the illness / condition related to: (please tick (☑) if YES)	Please provide details:
☑ **Hospitalisation** ☐ **Day Care** ☐ **On Patient's Request**	a) ☐ Pregnancy / Childbirth / Infertility/ Caesarean section/ miscarriage or any complications rising therefrom b) ☐ Congenital / Hereditary diseases c) ☐ Influence of Drugs / Alcohol d) ☐ Nervous / Mental / Emotional / Sleeping Disorder e) ☐ Cosmetic reason / Dental care / refractive errors correction f) ☐ AIDS / STD / VD/ HIV g) ☐ Self-inflicted injuries / Violation of laws / Strike / Riots h) ☑ None of the above	

12. Medical treatment, Investigations and Surgical procedure to be performed, if any (please supply copy of all investigation results): bloods / imaging / IV / ... / ... / IV meds / nebs / oral meds

13. Any other medical/surgical conditions present? ☐ No ☑ Yes, details below:

a.__________________ since____/____/____
b.__________________ since____/____/____

14. Was the patient pregnant at the time of Hospitalization? (For Female Only)

☐ No ☑ Yes, ________ 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) ________ ☐ am ☐ pm

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 med opinion of his/her condition.*

09/08/25
Date

Name & Signature of Attending Doctor
DR's Contact no and Email addresss:

Doctor / Hospital Stamp

DATO' SRI DR. SURESH RAJ LACHMANAN
S.S.A.P., D.G.S.M., S.I.M.P., D.C.S.M., D.P.N.S., C.S.A.P., D.I.M.P., D.S.D.P., D.K.S.D.,
MBBS (Mal.), MRCP (UK), MRCPS (Glas.), MAFP (Mal.),
RACGP (Aust.), ... (London),
MBA (Aust.), FAMM, FRCP (Edin), FRCP (Glasgow)
MMC Full Registration No:29045
Consultant Physician & Gastroenterologist
Assunta Hospital (17026-H)
(DR. CODE 2005)