



2210240272

PATIENT BILL

COMPANY ALLOCATION

FORMAT : DETAIL BREAK-UP

MICARE SDN BHD,
MICARE SDN BHD
NO 22 BLOCK A,
JALAN ASTAKA U8/84,
SECTION U8 BUKIT JELUTONG INDUSTRIAL PARK, SELANGOR,
40150, SHAH ALAM,
MALAYSIA

BILL NO : SMC-IP 10088425
BILL DATE : 10/10/2024
PATIENT NAME : LIM GIM SENG
IC / PASSPORT NO : 600726086069
MEDICAL RECORD NO : 1061514
VISIT ID : SMC-IP 1153828
ENCOUNTER TYPE : INPATIENT
VISIT TYPE : Endo
ADMITTING DOCTOR : DR OOI EE THIAM
ADMISSION DATE & TIME : 10/10/2024 07:51 AM
DISCHARGE DATE & TIME : 10/10/2024 05:50 PM

EMPLOYEE NAME :
RELATION :
EMPLOYEE NO :
GL REFERENCE NO : H0195534FGL10240004
CREDIT TERM : 30.00 Days
FINANCIAL TYPE : MICARE SDN BHD - MICARE 2023



HOSPITAL CHARGES

ROOM CHARGES

ACCOMMODATION

| 1-1030 | DAYCARE - DHC | (10/10/2024 - 10/10/2024) | DATE | QTY | GROSS AMOUNT | DISCOUNT | ALLOCATED AMOUNT |
|--------------------|---------------|-----------------------------|------|-----|--------------|----------|------------------|
| Total ROOM CHARGES | | | | 1 | 85.00 | 0.00 | 85.00 |
| | | | | | 85.00 | 0.00 | 85.00 |

HOSPITAL MEDICAL SERVICES

DIAGNOSTIC SERVICES

| | | | | | | |
|---------|-------------------------------|------------|---|--------|------|--------|
| 12-5033 | EN ENDO CONTAINER | 10/10/2024 | 1 | 4.00 | 0.00 | 4.00 |
| 12-5029 | EN ENDOSCOPY - PROCEDURE FEES | 10/10/2024 | 1 | 55.00 | 0.00 | 55.00 |
| 12-5031 | EN ENDOSCOPY NURSING CHARGES | 10/10/2024 | 1 | 88.00 | 0.00 | 88.00 |
| 12-4995 | EN ERCP THERAPEUTIC | 10/10/2024 | 1 | 715.00 | 0.00 | 715.00 |
| 12-5002 | EN POLAROID FILM | 10/10/2024 | 1 | 17.00 | 0.00 | 17.00 |
| 12-5027 | EN PORTABLE ENDO SERVIC | 10/10/2024 | 1 | 218.00 | 0.00 | 218.00 |

DRUGS FORMULARY

| | | | | | | |
|--------|--------------------------------------|------------|---|-------|------|-------|
| 4-556 | (I) DESFLURANE (SUPRANE) | 10/10/2024 | 1 | 5.90 | 0.29 | 5.61 |
| 4-84 | (I) FENTANYL 0.1MG/2ML INJ (HAMELN) | 10/10/2024 | 1 | 36.35 | 1.81 | 34.54 |
| 4-1383 | DEXAMETHASONE 8MG/2ML INJ (PENATONE) | 10/10/2024 | 1 | 41.15 | 2.05 | 39.10 |

ENDOSCOPY

| | | | | | | |
|----------|---------------------------|------------|---|--------|------|--------|
| 12-13847 | EN ENDOSCOPY RECOVERY BAY | 10/10/2024 | 1 | 132.00 | 0.00 | 132.00 |
|----------|---------------------------|------------|---|--------|------|--------|

EQUIPMENT USAGE

| | | | | | | |
|---------|-------------------------|------------|---|-------|------|-------|
| 12-1969 | EQ PULSE OXIMETER / 8HR | 10/10/2024 | 1 | 40.00 | 0.00 | 40.00 |
|---------|-------------------------|------------|---|-------|------|-------|

GENERAL SUPPLIES

| | | | | | | |
|-------------|---|------------|---|-------|------|-------|
| 7-190000072 | 001429 CONMED LARGE ADULT LATEX-FREE BITE BLOCK 20 X 27MM | 10/10/2024 | 1 | 42.25 | 0.00 | 42.25 |
| 7-152100004 | 1041 ADULT MEDIUM CONCENTRATION MASKS-ELONGATED | 10/10/2024 | 1 | 24.60 | 0.00 | 24.60 |
| 7-102100029 | 12" NITRILE POWDERED FREE GLOVES SIZE S 50S [PIECE] | 10/10/2024 | 2 | 5.50 | 0.00 | 5.50 |

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| FINANCIAL TYPE | : MICARE SDN BHD - MICARE 2023 | | |

| SERVICE CODE | DESCRIPTION OF SERVICE | DATE | QTY | GROSS AMOUNT | DISCOUNT | ALLOCATED AMOUNT |
|--------------------------------|--|------------|-----|--------------|----------|------------------|
| 7-132000052 | 2156000 INTERSURGICAL 22MM COMPACT, EXTENDABLE BREATHING SYSTEM WITH 2L BAG & 1.5M LIMB, 3.0 | 10/10/2024 | 1 | 221.00 | 0.00 | 221.00 |
| 7-121000012 | 3M TEGADERM IV ADVANCED 6.5CM X 7CM | 10/10/2024 | 1 | 12.95 | 0.00 | 12.95 |
| 7-164400002 | 409100H SAFEFLOW VALVE | 10/10/2024 | 1 | 19.55 | 0.00 | 19.55 |
| 7-103300001 | CPE PLASTIC GOWN BLUE | 10/10/2024 | 4 | 28.60 | 0.00 | 28.60 |
| 7-132000003 | CT6031 SECURE CONNECTING TUBE 6MM X 3.1M | 10/10/2024 | 1 | 31.35 | 0.00 | 31.35 |
| 7-138300002 | DISPOSABLE UNDERPAD 17" X 27" WITH SAP | 10/10/2024 | 1 | 3.60 | 0.00 | 3.60 |
| 7-164400011 | G-VS01 ENDO SAFIER - 4 SET KIT VALVE | 10/10/2024 | 1 | 95.85 | 0.00 | 95.85 |
| 7-152200015 | HYDRO GUARD MINI PLEATED HMEF WITH LUER LOCK PORT | 10/10/2024 | 1 | 47.70 | 0.00 | 47.70 |
| 7-145500001 | MEDI-TRACE 100 FOAM ELECTRODE PAEDIATRIC ECG | 10/10/2024 | 2 | 10.10 | 0.00 | 10.10 |
| 7-152200001 | PH006120 PHARMA COMBINED BACTERIA FILTER | 10/10/2024 | 1 | 39.90 | 0.00 | 39.90 |
| 7-125200003 | STERILE PLAIN GAUZE SWAB SIZE 5CM X 5CM X 8PLYS, PACK OF 5 PIECES | 10/10/2024 | 1 | 4.65 | 0.00 | 4.65 |
| 7-152400027 | TRACHEAL TUBE CUFF MURPHY 7.0 | 10/10/2024 | 1 | 72.60 | 0.00 | 72.60 |
| 7-315200002 | UI-SL1500S 1.5 LITRE SUCTION LINER (BLUE LID) WITH SHUT OFF VALVE & FILTER | 10/10/2024 | 1 | 45.30 | 0.00 | 45.30 |
| 7-133000010 | VASOFIX SAFETY G22 X 25MM FEP | 10/10/2024 | 1 | 15.35 | 0.00 | 15.35 |
| 7-315200001 | YANKAUER SUCTION TIP CROWN UNVENTED | 10/10/2024 | 1 | 28.05 | 0.00 | 28.05 |
| HOSPITAL SUPPORT FEES | | | | | | |
| 12-14004 | CSD CSSD SUPPORT FEE (ENDOSCOPY) | 10/10/2024 | 1 | 220.00 | 11.00 | 209.00 |
| MEDICAL RECORD SERVICES | | | | | | |
| 12-2400 | ADMISSION FEE | 10/10/2024 | 1 | 66.00 | 0.00 | 66.00 |
| MEDICAL SUPPLIES | | | | | | |
| 12-6628 | 3PLY SURGICAL FACE MASK TIE ON, DISPOSABLE | 10/10/2024 | 1 | 0.80 | 0.00 | 0.80 |
| 12-6671 | NON-STERILE GAUZE 10X10 (5PC) | 10/10/2024 | 3 | 24.00 | 0.00 | 24.00 |
| 4-4069 | SODIUM CHLORIDE 0.9% 20ML 3613305 | 10/10/2024 | 2 | 10.30 | 0.51 | 9.79 |
| NURSING SERVICES | | | | | | |
| 12-2705 | OR OT NURSING SUPPORT/PER HOUR | 10/10/2024 | 3 | 249.00 | 0.00 | 249.00 |
| PHARMACY SERVICES | | | | | | |
| 12-9433 | COLIMIX SYR PER DOSE | 10/10/2024 | 1 | 7.80 | 0.00 | 7.80 |
| PPE SUPPLIES | | | | | | |
| 7-102100035 | 9" NITRILE POWDERED FREE EXAM GLOVE SIZE L 100S | 10/10/2024 | 2 | 1.20 | 0.00 | 1.20 |
| 7-102100034 | 9" NITRILE POWDERED FREE EXAM GLOVE SIZE M 100S | 10/10/2024 | 6 | 3.60 | 0.00 | 3.60 |
| 7-102100033 | 9" NITRILE POWDERED FREE EXAM GLOVE SIZE S 100S | 10/10/2024 | 14 | 8.40 | 0.00 | 8.40 |
| RADIOLOGY SERVICES | | | | | | |
| 12-4716 | RD NON IONIC CONTRAST 50MLS | 10/10/2024 | 1 | 256.00 | 12.80 | 243.20 |
| 2-73301 | RF, ERCP UNDER GA | 10/10/2024 | 1 | 1,381.00 | 69.05 | 1,311.95 |
| SURGICAL SUPPLIES | | | | | | |

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|--|--|------------|-----|-----------------|--------------|------------------|
| 7-370000004 | M00547100 EXTRACTOR PRO XL 9-12 MM ABOVE | 10/10/2024 | 1 | 1,384.90 | 0.00 | 1,384.90 |
| 7-358000001 | M00562301 CAPTIVATOR SNARE OVAL STIFF 13MM | 10/10/2024 | 1 | 286.00 | 0.00 | 286.00 |
| Total HOSPITAL MEDICAL SERVICES | | | | 6,000.30 | 97.51 | 5,902.79 |
| Total HOSPITAL CHARGES | | | | 6,085.30 | 97.51 | 5,987.79 |

CONSULTANT(S) FEES

● DR HAIRATUN IDA BINTI MD HAMZAH (ANAESTHESIOLOGY & CRITICAL CARE)

PROCEDURE FEES

| | | | | | | |
|------------|---|------------|---|--------|------|--------|
| J4303 100% | ERCP, THERAPEUTIC PROCEDURE, REMOVAL OF CALCULI, WITH OR WITHOUT SPHINCTEROTOMY, FROM THE BILIARY AND/OR PANCREATIC DUCTS | 10/10/2024 | 1 | 940.00 | 0.00 | 940.00 |
| | | | | 940.00 | 0.00 | 940.00 |

CONSULTATION FEES

| | | | | | | |
|------------------|--------------------------------|------------|---|--------|------|--------|
| 8202C3 100% 025C | FIRST [INPATIENT] CONSULTATION | 10/10/2024 | 1 | 235.00 | 0.00 | 235.00 |
| 8202C3 100% 020C | WARD VISIT | 10/10/2024 | 1 | 105.00 | 0.00 | 105.00 |

340.00 0.00 340.00

● DR OOI EE THIAM (GASTROENTEROLOGY & HEPATOLOGY)

PROCEDURE FEES

| | | | | | | |
|------------|---|------------|---|----------|------|----------|
| J4303 100% | ERCP, THERAPEUTIC PROCEDURE, REMOVAL OF CALCULI, WITH OR WITHOUT SPHINCTEROTOMY, FROM THE BILIARY AND/OR PANCREATIC DUCTS | 10/10/2024 | 1 | 1,890.00 | 0.00 | 1,890.00 |
| | | | | 1,890.00 | 0.00 | 1,890.00 |

CONSULTATION FEES

| | | | | | | |
|------------------|--------------------------------|------------|---|--------|------|--------|
| 8202C3 100% 025C | FIRST [INPATIENT] CONSULTATION | 10/10/2024 | 1 | 235.00 | 0.00 | 235.00 |
| 8202C3 100% 020C | WARD VISIT | 10/10/2024 | 1 | 105.00 | 0.00 | 105.00 |

340.00 0.00 340.00

Total CONSULTANT(S) FEES

3,510.00 0.00 3,510.00

GRAND TOTAL

9,595.30 97.51 9,497.79

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|--------------|------------------------|------|-----|--------------|----------|------------------|

PAYABLE BY PATIENT

| | |
|------------|----------|
| AMOUNT DUE | 9,497.79 |
|------------|----------|



PRE-AUTHORISATION FORM

Borang Pra-kebenaran
Private and Confidential / Sulit dan Persendirian

MiCare Sdn Bhd
Block A, No. 22,
Jalan Astaka U8/84,
Seksyen U8, Bukit Jelutong,
40150 Shah Alam,
Selangor Darul Ehsan

24 HOURS HOTLINE:
+603-7839 7813
Fax: +603-7840 0832

Part 1 (To be completed by Patient / Claimant)
Bahagian 1 (Untuk diisi oleh Pesakit / Penuntut)

| | | | |
|---|---|---|--|
| 1. Patient Name: <i>Nama Pesakit</i> | 2. NRIC (Old & New): <i>K.P. (Lama & Baru)</i> 600726086069 | | |
| 3. a. Date of Birth: <i>Tarikh lahir</i> | b. Age: <i>Umur</i> | c. Sex: <i>Jantina</i> | <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female <i>Laki-laki</i> <i>Perempuan</i> |
| 36/07/1960 | 64 | | |
| 4. Policy No. / Member ID/ Certificate No/ Plan/ Company Name : <i>No. Polisi / No. Ahli / No. Sijil / Pelan / Nama Syarikat</i> | 5. Admission / Planned Admission Date: <i>Tarikh kemasukan hospital</i> 10/10/24 | | |
| 6. Hospital Name: <i>Nama Hospital</i> | 7. Name of Attending Doctor/ Speciality: <i>Nama Doktor yang merawat/ Kepakaran:</i> DR OOIEE THIAH | | |
| Admission Reason (tick) and answer accordingly <i>Sila tanda () dan jawab soalan yang berkenaan</i> | | | |
| 8. Accident <i>Kemalangan</i> | a. Occurred on: <i>Bertaku pada</i> | Date _____ / _____ / _____ <i>Tarikh</i> | Time _____ <i>Masa</i> <input type="checkbox"/> am <input type="checkbox"/> pm <i>pagi</i> <i>petang</i> |
| | b. Details of Accident: <i>Butir-butir kemalangan</i> | | |
| 9. Illness <i>Penyakit</i> | a. Symptoms first appeared on: <i>Tarikh simptom tersebut bermula</i> | Date _____ / _____ / _____ <i>Tarikh</i> | |
| | b. Doctor(s) consulted for this condition: <i>Doktor-doktor yang dilawati bagi penyakit ini</i> | | |
| | c. Doctor's or Clinic Contact(Address & Telephone): <i>Alamat & Telefon Doktor</i> | | |

10. Declaration and authorization

I declare that the answers given above are true and complete to the best of my knowledge and belief.

I, the undersigned, understand the delivery of this form is in no way an admission of claim by MiCare/Payor Company and payment to the hospital by MiCare/Payor Company or its representative shall not be construed as final admission of claim by MiCare/Payor Company for this and any further claims arising, MiCare/Payor Company reserves all rights for evaluation as appropriate.

I am fully aware of the limits as to my/covered person's medical/Assured's medical insurance/Takaful entitlement under the above-mentioned policy. I hereby undertake to settle/reimburse any medical expenses exceeding my entitlement under the said policy contract/Takaful coverage, or that is not covered by the same.

I hereby irrevocably authorize any organisation, 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 MiCare/Payor Company or its representative such information. I agree that MiCare/Payor Company or its representative may use or disclose any of the information collected or held to third parties (within or outside Malaysia, including MiCare/Payor Company's parent company, subsidiaries or any other associated companies within the MiCare/Payor Company Group, reinsurers/re-takaful, 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, MiCare/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.

Pengisyiharan dan pemberikuasa

Saya mengisyiharkan bahawa jawapan yang diberikan di atas adalah benar dan lengkap setakat pengetahuan dan kepercayaan saya.

Saya memahami bahawa penyerahan borang ini, tidak sama sekali boleh dianggap sebagai persetujuan tuntutan saya/orang yang dilindungi ke atas MiCare/Syarikat Pembayar dan saya bersetuju bahawa bayaran kepada hospital oleh MiCare/Syarikat Pembayar atau wakinya tidak akan ditelaah sebagaimana persepsi muktamad tuntutan ke atas MiCare/Syarikat Pembayar dan MiCare/Syarikat Pembayar berhak menjalankan ponakan sewajarnya berhubung tuntutan ini atau apa-apa tuntutan yang timbul selanjutnya.

Saya memahami sepenuhnya had-had kelayakan/Takaful/Perubatan saya di bawah Polisi yang tersebut di atas. Saya dengan ini berjanji akan menyelesaikan sebarang dan segala perbelanjaan perubatan yang mewujudkan kadar kelayakan saya, yang tidak dilindungi oleh Polisi berkenaan.

Saya yang berjandangan di bawah, dengan ini membentarkan pada setiap mase, mana-mana organisasi, institusi atau individu yang mempunyai apa-apa rekod atau pengeluaran tentang keshalan dan latar belakang atau rawatan atau nasihat perubatan saya/orang yang dilindungi, yang telah atau mungkin kemudian dari ini dirujuk untuk mendedahkan kepada MiCare/Syarikat Pembayar atau wakinya segala maklumat tersebut. Saya bersetuju membentarkan MiCare/Syarikat Pembayar atau wakinya untuk menggunakan dan mendedahkan apa-apa maklumat yang dikumpul atau dipergang kepada pihak ketiga (di dalam atau di luar Malaysia, termasuk syarikat induk, anak syarikat atau syarikat berkait dalam Syarikat, syarikat reinsursus/re-takaful, pemerka perubatan, penjagaan tuntutan dan pertubuhan/persekutuan industri dil.) berkaitan dengan tuntutan ini. Pengesahan ini hendaklah mengikuti waris-waris dan penamaan saya/ nyawa yang dilindungi dan kekal sah meskipun setelah kemalangan saya/orang yang dilindungi setakat yang dibenarkan di sisi undang-undang. Salinan pengesahan ini adalah sah. Saya bersetuju sekiranya saya membuat pengakuan palsu atau tidak mendedahkan maklumat yang berkaitan, MiCare/Syarikat Pembayar berhak membatakan tuntutan saya dan menarik balik sebarang tuntutan awal yang telah dibayar.

| | | |
|--|--|---|
| Signature of Patient / Tandatangan Pesakit | Signature of Covered person/ claimant / Tandatangan Orang yang dilindungi /Penuntut | Signature of Witness / Tandatangan Saksi |
| | | |
| Full Name/Nama Penuh: Lim Gim Seng IC No./No. KP: 600726086069 Date/Tarikh: Contact No / No Telefon: 012-3352060 | Full Name/Nama Penuh: Lim Gim Seng IC No./No. KP: 600726086069 Date/Tarikh: Contact No / No Telefon: Relationship to Patient/ Hubungan dengan Pesakit: | Full Name/Nama Penuh: Nurul Atiqah IC No./No. KP: Date/Tarikh: Contact No / No untuk dihubungi: |

NOTE: COMPLETION OF THIS PRE AUTHORISATION FORM DOES NOT GUARANTEE THE ISSUANCE OF GUARANTEE LETTER.
Nota: Melengkapkan borang permintaan ini tidak semestinya menjamin bahawa Surat Jaminan akan dikeluarkan.

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

1.a. Patient name:

LIM GIM SENG

b. NRIC:

600726086069

c. Age:

64

d. Sex: Male Female

2. Policy No. / Member ID/ Certificate No.:

3. Hospital Name/ Hospital Contact and Fax No.:
Admission No. / MRN

SUN MED

4. Admission Date and Time:

10/10/24

5. Expected days of stay / Discharge Date:

6. a. Symptoms / Conditions requiring admission:

Removal of biliary stent (Cape)

b. How long is patient aware of the condition:

One month

c. Patient's BP/ Temp/ Pulse:

19/200 124/76

d. Date symptoms first appeared:

6/9/2024

e. Date first consulted:

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:

before by Dr Bay J.

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

9/2024 Post cholecystectomy bile leak Dr Bay J.

d. Can the condition be managed under the Outpatient basis? Yes No If no please provide reasons of admission:

Cape will be removed anaesthetically

8. a. Admitting Diagnosis:
or

b. Provisional Diagnosis:

c. Diagnosis confirmed on 10/10/2024 Cane.

d. Advised patient on 10/10/2024

Urine

9. Estimated Total Costs: RM

Removal of biliary stent
Cape

e. Any possibility of relapse? Yes No

10. a. Admission requires:

Hospitalisation
 Day Care
 On Patient's Request

11. Is the illness / condition related to: (Please tick V if YES)

Please provide details:

- a. Pregnancy / Childbirth / Infertility / Caesarean section/ miscarriage
Or any complications arising 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):

Removal of biliary stent

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:

No

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 medical opinion of his/her condition.

8/10/2024

Date Name & Signature of Attending Doctor

Contact no. and Email

Dr. Ooi Le Thiam

MMC Full Registration No. 35900

MBBS (Malaya), MSc Med / Hospital Stamp

Consultant Gastroenterologist & Hepatologist

SUNWAY MEDICAL CENTRE SDN BHD

198501012553 (341885-X)

DISCHARGE SECTION (To Be Completed Upon Discharge by Doctor)

17. Undertaking Letter Ref No. (if available):

18. Date of Discharge:

19. a. Final Diagnosis:

b. Cause and pathology of the diagnosis:

Removal of CRN stone & biliary stent

ICD code:

20. Treatment given / Investigation done (Please supply copy of all investigation results):

as above

b. Date of surgery / procedure:

as above

21. a. Surgical procedures performed:

MMA code / IHSR code:

22. e. Recovery complication that arose (if any):

No

Dr. Ooi Le Thiam

MMC Full Registration No. 35900

MBBS (Malaya), MRCP (UK)

Consultant Gastroenterologist & Hepatologist

SUNWAY MEDICAL CENTRE SDN BHD

198501012553 (341885-X)

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/her injuries/illness described above and that the facts as stated above represent my medical opinion of his/her condition.

10/10/2024

Name & Signature of Attending Doctor

Doctor / Hospital Stamp