

KUALA LUMPUR HYPERBARIC CENTER

PATIENT REFERRAL FORM / BORANG RUJUKAN PESAKIT



To / Kepada :

Medical Officer / Pegawai Perubatan
Kuala Lumpur Hyperbaric Centre

Tarikh / Date : _____

Maklumat Pesakit / Patient's Particulars

Nama / Name : _____

No Kad Pengenalan / NRIC : _____

Umur / Age : _____ Jantina / Sex : _____

Bangsa / Race : _____ Agama / Religion : _____

Dirujuk untuk masalah berikut / Referred for conditions as listed below :

- Wound Healing : Diabetic Foot / Ulcer
 Non Diabetic Chronic Ulcer/ Wound
 Thermal Burns
 Compromised Skin Grafts / Flaps
 Crush Injuries
 Gas Gangrene
 Others wound(please specify) _____

- Carbon Monoxide Poisoning or Smoke Inhalation
 Cerebral Palsy
 Others (please specify) _____
- Bell's Palsy
 Stroke

Penyakit Diketahui / Known Illness

- | | | | | | |
|--------------------|----------------------------------------------------------|--------------|----------------------------------------------------------|------------------------|----------------------------------------------------------|
| Diabetis Mellitus | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypertension | <input type="checkbox"/> Yes <input type="checkbox"/> No | Coronary Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchial Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | ENT Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lain-lain penyakit | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |

Sejarah Pembedahan / *Surgical History* : _____

Ubatan / *Current Medication* : _____

Notes : _____

Dirujuk oleh / Referred by : _____

Tandatangan / Signature _____

Nama & Chop /
Name & Stamp _____

Peta Lokasi :



KUALA LUMPUR HYPERBARIC CENTER
NEW PATIENT ASSESSMENT



Patient Name : _____
 Referred From : _____
 HBO Physician : _____
 Possible HBOT Indication : _____

Medical / Surgical History

	YES	NO		YES	NO
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	H/O Thoracic Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	H/O Heart Complications	<input type="checkbox"/>	<input type="checkbox"/>
Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>	H/O ENT Surgery/ Ds	<input type="checkbox"/>	<input type="checkbox"/>
Cong. Spherocytosis	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker in-situ	<input type="checkbox"/>	<input type="checkbox"/>
Bronchiol Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	H/O Respiratory Infections	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>
H/O Pneumothorax	<input type="checkbox"/>	<input type="checkbox"/>	URTI	<input type="checkbox"/>	<input type="checkbox"/>
H/O Optic Neuritis	<input type="checkbox"/>	<input type="checkbox"/>	Other known illness	_____	

Other History

Smoking : YES NO _____ packets per day
 Medication : YES NO _____
 (medicine)
 Last meal _____
 Related Medical/Surgical Hx: _____

General Examination

Patients able to communicate : _____
 Appearance: _____

Physical Conditions : Able to walk unassisted
 Able to walk with assistance
 Able to sit using wheelchair
 Bed-ridden

Respiratory Syst _____ Cardiovascular syst _____
 Abdomen _____ CNS _____
 Other Findings _____

Body Temperature : °C RBS : mmol/L
 Blood Pressure mmHg Pulse Rate: /min
 Regular/Irregular

Assessed by,

