CMH HOSPITAL PAKAR CMH SPECIALIST HOSPITAL
泰華專科醫院

Ref No:

MEDICAL REPORT APPLICATION FORM

For enquiry, please call 06-763 1688 ext. 320 or 012-2645313 (WhatsApp) or email to medicalrecord@cmhspecialist.my

Note: *Processing period is 15-20 working days.*

PART A: PATIENT PARTICULAR

Patient's Name			
NRIC/ Passport No.		**MRN**	
Admission/Visit Date		**Contact No.**	
Attending Doctor			

PART B: REQUESTOR PARTICULAR

Requestor's Name		**Contact No.**	
NRIC/ Passport No.		**Email**	
Relationship	☐ Self ☐ Next of kin ☐ Agent ☐ Others (specify): _____		
Method of application	☐ Walk-in ☐ Email ☐ WhatsApp ☐ Courier ☐ Others (specify): _____		
Collection/Delivery Preference	☐ Self-collect ☐ Email: _____ ☐ Post (***RM8 – subject to courier changes***): _____		

PART C: APPLICATION DETAIL

No	Description	Fee (RM)	(✓)
Written Medical Report			
1	Personal	**RM150**	
2	Insurance (MAR)	**RM150**	
3	Others (specify)	**RM150**	
4	Police Report/ Government Report/ Declaration Letter	**FOC**	
Forms			
5	Insurance Form – Company (specify): ☐ Attending Physician Statement ☐ Accident Claim Form ☐ Hospitalisation Form	**1 page - RM60** **2 pages – RM80** **>3 pages – RM100** **>5 pages – RM150**	
6	Obstetrics & Gynaecology	**RM100**	
7	SOCSO/PERKESO	**RM40**	
8	EPF/KWSP/Healing Progress	**RM50**	
9	All NGO's Form, OKU, Baitulmal & Etc.	**FOC**	
Medico-Legal Report			
10	Standard Report	**RM300-RM800**	
11	Detailed Report	**RM800-RM1500**	
12	Clarification Report	**FOC**	
Copy of Report/Others			
13	Copy of Discharge Summary/Investigation Report/Medical Certificate		
14	Endorsement on Receipt (Final Diagnosis)	**FOC**	
15	Others (specify): _____		
16	Courier Service Charge	**RM8**	
	TOTAL		

MEDICAL REPORT APPLICATION FORM (Cont.)

PART D: CONSENT BY PATIENT/NEXT-OF KIN/PARENT/GUARDIAN

I hereby consent unequivocally to CMH Specialist Hospital to provide my personal data & sensitive personal data including but not limited to my medical information contained in the medical records of * myself / my child / next of kin _____

(Name of Patient)

to _____

(Person Name or Name of Organization)

and hereby unconditionally release CMH Specialist Hospital from all legal responsibility or liability that may arise from this consent.

By signing the below, I hereby confirm that the information provided above is accurate, correct & complete & the documents submitted along with this application form are genuine.

Patient/Next-of Kin/Parent/Guardian	☐ **Consent provided/given separately**
Signature: _____ Name: _____ Date : _____	

Part E: Important Note

If you are the patient	1) Fill in Part **A, B, C** and **D.** 2) Please provide a copy of your NRIC/Passport. 3) Application will be processed after receiving full payment 4) If you are sending a representative to collect the report, an authorised letter signed by patient is required upon collection.
If you are the patient's representative	1) Fill in Part **A, B** and **C.** 2) Get the patient/parent/next of kin to sign in Part **D.** 3) Please provide a copy of patient's NRIC / Passport & copy of requestor/ representative's NRIC/Passport. 4) If the patient is deceased, please attach a copy of patient's death certificate. 5) Application will be processed after receiving full payment. 6) If you are sending a representative to collect the report, please provide an authorized letter required upon collection.

Requested By:	**Collected By:**
Signature: _____ Name: _____ Date : _____	Signature: _____ Name: _____ Date : _____

FOR MEDICAL RECORD OFFICE USE

Payment Method: ☐ Counter ☐ Online Banking ☐ Cheque

Receipt Payment No: _____ Receipt Date: _____

Remarks: _____