

NATIONAL MEDICAL CARE SURVEY (NMCS) Primary Care and Ambulatory Care Services

Office use: /
Centre:

- Instruction: 1. Thank you for taking the time to answer this survey questionnaire.
2. A visit is defined as an episode of doctor-patient consultation.
3. Where check boxes are provided, check one or more boxes. Where radio buttons are provided, check one box only.
4. Please complete all the relevant sections.

5. Please return the completed form(s) by / / via either fax at 03-4043 9500 or post using the prepaid envelope provided to:

KEMENTERIAN KESIHATAN MALAYSIA
Clinical Research Centre Surveys and Research Projects
3rd Floor MMA House,
124 Jalan Pahang,
53000 Kuala Lumpur.

6. If you prefer to submit the information electronically, you may do so using our online survey questionnaire accessible at <http://www.crc.gov.my/nhsi>
7. For any queries, kindly contact the Healthcare Statistics Unit at 03 4043 9300/ 03 4043 9400 or email hsu@crc.gov.my

i) Clinic Name : ii) Clinic ID :

SECTION 1 : PATIENT IDENTIFICATION AND CHARACTERISTICS

1. Date of Visit : (dd/mm/yyyy)	<input type="text"/> / <input type="text"/> / <input type="text"/>		
2. NRIC :	MyKad/ MyKid: <input type="text"/> - <input type="text"/> - <input type="text"/>	Old IC: <input type="text"/>	
	Other ID document No: <input type="text"/>		
	Specify document type (if others):	<input type="radio"/> Registration number <input type="radio"/> Birth Certificate <input type="radio"/> Hospital RN <input type="radio"/> Police ID Card <input type="radio"/> Passport <input type="radio"/> Mother's I/C <input type="radio"/> Armed Force ID <input type="radio"/> Unregistered <input type="radio"/> Drivers Licence <input type="radio"/> Father's I/C <input type="radio"/> Work Permit # <input type="radio"/> Others	
3. Sex :	<input type="radio"/> Male <input type="radio"/> Female	4. Marital status :	<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Unspecified
5. Date of Birth : (dd/mm/yyyy)	<input type="text"/> / <input type="text"/> / <input type="text"/>	6. Age : (Autocalculated)	<input type="text"/> (years)
7. Nationality :	<input type="radio"/> Malaysian <input type="radio"/> Foreigner, specify : _____		
8. Ethnic group :	<input type="radio"/> Malay <input type="radio"/> Indian <input type="radio"/> Kadazan Dusun <input type="radio"/> Murut <input type="radio"/> Bidayuh <input type="radio"/> Orang Ulu <input type="radio"/> Others, specify: <input type="radio"/> Chinese <input type="radio"/> Orang Asli <input type="radio"/> Melanau <input type="radio"/> Bajau <input type="radio"/> Iban <input type="radio"/> Unknown / Not Applicable		

SECTION 2 : CURRENT CONDITION/ REASON FOR VISIT

1. Major reason for visit :	<input type="radio"/> Acute Illness		
	<input type="checkbox"/> Upper respiratory tract infection (URTI) <input type="checkbox"/> Otitis media <input type="checkbox"/> Dermatitis, Eczema <input type="checkbox"/> Soft Tissue disorders <input type="checkbox"/> Acute gastroenteritis (AGE) <input type="checkbox"/> Urinary Tract Infection (UTI) <input type="checkbox"/> Dyspepsia <input type="checkbox"/> Others, specify: _____		
	Is the visit related to any of the following? (If applicable)		
	<input type="checkbox"/> Unintentional injury/poisoning <input type="checkbox"/> Injury/poisoning/unknown intent <input type="checkbox"/> Intentional injury/poisoning <input type="checkbox"/> Adverse effect of medical/surgical care, drug(s)		
	Primary diagnosis : <input type="text"/>		
	<input type="radio"/> Chronic Illness (Flare-up/routine follow up)		
	<input type="checkbox"/> Essential Hypertension <input type="checkbox"/> Asthma <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Chronic obstructive pulmonary disorder (COPD) <input type="checkbox"/> Congestive heart failure (CHF) <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Chronic renal failure <input type="checkbox"/> Cancer <input type="checkbox"/> Ischemic heart disease <input type="checkbox"/> Others, specify: _____		
	<input type="radio"/> Preventive Care		
	<input type="checkbox"/> Medical Check-up (FOMEMA) <input type="checkbox"/> Medical Examination for Insurance/boarding school/college application <input type="checkbox"/> Antenatal checkup <input type="checkbox"/> Postnatal care <input type="checkbox"/> Immunization		
	<input type="checkbox"/> BCG (TB) <input type="checkbox"/> Hepatitis B <input type="checkbox"/> MMR (Measles, mumps and rubella) <input type="checkbox"/> DPT (Diphtheria, pertussis, tetanus) <input type="checkbox"/> Hib (Haemophilus influenzae b) <input type="checkbox"/> OPV/IPV (polio vaccine) <input type="checkbox"/> DT (Diphtheria and Tetanus) <input type="checkbox"/> Well baby visits <input type="checkbox"/> Routine gynae examination (eg. pap smear) <input type="checkbox"/> T (Tetanus) <input type="checkbox"/> Others, please specify: _____ <input type="checkbox"/> Others (State) : _____		

SECTION 3 : VISIT DISPOSITION

1. Visit disposition :	<input type="radio"/> No follow-up planned <input type="radio"/> Return at specified time <input type="radio"/> Telephone follow-up planned <input type="radio"/> Admit to hospital <input type="radio"/> Return if needed. PRN <input type="radio"/> Refer to other physician <input type="radio"/> Refer to emergency department <input type="radio"/> Others, specify: _____
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SECTION 4 : SOURCE OF PAYMENT

1. Source of payment :	<input type="checkbox"/> Private Household - out of pocket <input type="checkbox"/> Private Employer/ Corporations <input type="checkbox"/> Ministry of Health (MOH) <input type="checkbox"/> Others, specify: <input type="checkbox"/> Private Managed Care Organisation (MCO)/ similar entities <input type="checkbox"/> Private Insurance <input type="checkbox"/> Other government agencies <input type="checkbox"/> Unknown <input type="checkbox"/> SOCSO
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Instruction: 1. Where check boxes are provided, check (✓) one or more boxes. Where radio buttons are provided, check (✓) one box only.

i) Clinic Name : ii) Clinic ID :

iv) NRIC :

SECTION 5 : MEDICATION DETAILS

No	Drug Name & Form (brand/generic)	Strength/ Unit	Route	Dosage	Dose Unit	Frequency	Duration	Total
	Type : <input type="radio"/> New <input type="radio"/> Continue		<input type="radio"/> Oral/po/o/suck <input type="radio"/> IM <input type="radio"/> Topical/LA/apply/local <input type="radio"/> Inhal/inh/Inhaler <input type="radio"/> Eye drops <input type="radio"/> Rectal/Supp/PR <input type="radio"/> Others <input type="text"/>	<input type="text"/>	<input type="radio"/> Tablet/tab/caps <input type="radio"/> mg <input type="radio"/> ml/cc/mls <input type="radio"/> Teaspoon/tsp <input type="radio"/> Tablespoon/tbsp <input type="radio"/> Bottle <input type="radio"/> Drop <input type="radio"/> Other <input type="text"/>	<input type="radio"/> Stat <input type="radio"/> prn <input type="radio"/> od/daily/once <input type="radio"/> on/om <input type="radio"/> bd <input type="radio"/> tds <input type="radio"/> qid/qds <input type="radio"/> Others <input type="text"/>	<input type="text"/> <input type="radio"/> Day <input type="radio"/> Week <input type="radio"/> Month	<input type="text"/> Unit : <input type="radio"/> Tab/Cap <input type="radio"/> Gm/g <input type="radio"/> Bottle/Can <input type="radio"/> ml/mls <input type="radio"/> Oz <input type="radio"/> Other <input type="radio"/> Tube <input type="text"/> <input type="radio"/> suppository/Supp <input type="text"/> <div style="text-align: right; border: 1px solid black; padding: 2px; width: 30px; float: right;">ADD</div>
				<input type="radio"/> Oral/po/o/suck <input type="radio"/> IM <input type="radio"/> Topical/LA/apply/local <input type="radio"/> Inhal/inh/Inhaler <input type="radio"/> Eye drops <input type="radio"/> Rectal/Supp/PR <input type="radio"/> Others <input type="text"/>	<input type="text"/>	<input type="radio"/> Tablet/tab/caps <input type="radio"/> mg <input type="radio"/> ml/cc/mls <input type="radio"/> Teaspoon/tsp <input type="radio"/> Tablespoon/tbsp <input type="radio"/> Bottle <input type="radio"/> Drop <input type="radio"/> Other <input type="text"/>	<input type="radio"/> Stat <input type="radio"/> prn <input type="radio"/> od/daily/once <input type="radio"/> on/om <input type="radio"/> bd <input type="radio"/> tds <input type="radio"/> qid/qds <input type="radio"/> Others <input type="text"/>	<input type="text"/> <input type="radio"/> Day <input type="radio"/> Week <input type="radio"/> Month
	Type : <input type="radio"/> New <input type="radio"/> Continue		<input type="radio"/> Oral/po/o/suck <input type="radio"/> IM <input type="radio"/> Topical/LA/apply/local <input type="radio"/> Inhal/inh/Inhaler <input type="radio"/> Eye drops <input type="radio"/> Rectal/Supp/PR <input type="radio"/> Others <input type="text"/>	<input type="text"/>	<input type="radio"/> Tablet/tab/caps <input type="radio"/> mg <input type="radio"/> ml/cc/mls <input type="radio"/> Teaspoon/tsp <input type="radio"/> Tablespoon/tbsp <input type="radio"/> Bottle <input type="radio"/> Drop <input type="radio"/> Other <input type="text"/>	<input type="radio"/> Stat <input type="radio"/> prn <input type="radio"/> od/daily/once <input type="radio"/> on/om <input type="radio"/> bd <input type="radio"/> tds <input type="radio"/> qid/qds <input type="radio"/> Others <input type="text"/>	<input type="text"/> <input type="radio"/> Day <input type="radio"/> Week <input type="radio"/> Month	<input type="text"/> Unit : <input type="radio"/> Tab/Cap <input type="radio"/> Gm/g <input type="radio"/> Bottle/Can <input type="radio"/> ml/mls <input type="radio"/> Oz <input type="radio"/> Other <input type="radio"/> Tube <input type="text"/> <input type="radio"/> suppository/Supp <input type="text"/> <div style="text-align: right; border: 1px solid black; padding: 2px; width: 30px; float: right;">ADD</div>
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i) Completed by : (signature and name) ii) Date completed : (dd/mm/yyyy) / /