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memo

**HOSPITAL SULTAN ABDUL AZIZ SHAH (HSAAS)**

**UNIVERSITI PUTRA MALAYSIA**

|  |  |
| --- | --- |
| **MEMO PERMOHONAN PESARA PERSEKUTUAN TARIKH:** | |
| Kepada | **Unit Kaunseling Kerja Sosial Perubatan**  **Hospital Sultan Abdul Aziz Shah (HSAAS), UPM** |
| Daripada |  |
| Perkara | **PERMOHONAN PERBELANJAAN KEMUDAHAN PERUBATAN (UBAT/ALAT/PERKHIDMATAN/ RAWATAN) UNTUK PESARA AWAM PERSEKUTUAN** |

Assalamualaikum dan Salam Sejahtera.

Tuan/Puan,

Nama Pesakit : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MRN : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Diagnosis* : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nama Ubat/Alat : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SEKIRANYA PERMOHONAN ADALAH MELIBATKAN **UBAT**, MOHON ISI RUANGAN DI BAWAH:

|  |  |  |  |
| --- | --- | --- | --- |
| *Dose & Frequency* | : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| *Duration of Treatment* | : |  | *One- Off Treatment* |
|  |  |  | 3 Bulan |
|  |  |  | 6 Bulan |
|  |  |  | 12 Bulan (Penggunaan Ubat Jangka Masa Panjang) |
|  |  |  | Lain-lain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Keperluan Segera | : Ya Tidak | | |
|  | Jika ya, nyatakan sebab: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

Peringatan : Pihak tuan/puan adalah **bertanggungjawab sepenuhnya** untuk memastikan alatan yang dipohon

**mempunyai sijil *Medical Device Authority (MDA)* dan *Letter Of Authorization (LOA)*yang sah.**

Sekian, terima kasih.

**“MALAYSIA MADANI”**

**“BERILMU BERBAKTI”**

Saya yang menjalankan amanah,

**.......................................................  
Nama :**

**Cop & Jawatan :**

**No. Tel & Emel :**

**Tarikh :**

*\*Sila pastikan Senarai Semak* ***LENGKAP****. (Rujuk lampiran di belakang)*

*\*Pastikan memo ini diisi secara* ***BERTAIP***

**Senarai Semak (Tandakan / pada yang berkaitan)**

|  |  |
| --- | --- |
|  | Borang Perubatan 1/09 |
|  | Salinan Kad Pengenalan (IC) Pesara **( Depan Belakang )** |
|  | Salinan Kad Pesara (Hanya kod pesara **AP, AS, AT, AX, AZ, BP, BS, BT** sahaja yang diterima) **(Depan Belakang)** |
|  | Tiga (3) Sebut Harga Pembekal **(Sila turunkan tandatangan pada sebut harga pilihan)** |
|  | Salinan Sijil Lahir Anak/Salinan IC Pasangan (jika pesakit adalah tanggungan pesara) **(Depan Belakang)** |
|  | Surat Pengesahan Institusi Pendidikan/Pengajian Tinggi **(jika berkaitan)** |
|  | Lain-lain dokumen yang berkaitan **(resit, invois dll)** |

|  |  |
| --- | --- |
| **UNTUK KEGUNAAN PEJABAT** | |
| Diterima oleh:  ........................................................  Nama :  Cop & Jawatan :  Tarikh : | CATATAN: |

*Kemaskini: 6/04/2023*