SELF-REFERRAL (CLINIC) FORM

PSYCHIATRY ADOLESCENT & CHILD UNIT
DEPARTMENT OF PSYCHOLOGICAL MEDICINE
UNIVERSITY MALAYA MEDICAL CENTRE

Please make sure that this form is complete. Tarikh / *Date*: ……..

Nama Pesakit / *Patient's Name*: ……. R/N : ……...

Tarikh Lahir / *Date of Birth*: ……..……. Umur / *Age*: ……..…….. Jantina / *Sex*: ……

Masalah Dihadapi / *Chief Complaint(s)*:

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……..……

Dirujuk oleh / *Referred By* (cth. ibu / bapa / doktor - nama): ……..

Nama ibu / bapa / penjaga / *Mother's / Father's / Guardian's Name*: ……

Alamat Penuh / *Full Address*: ..……..……..

……..……..……

……..……

Nombor Telefon / *Contact Number* :

Rumah / *House* :……..……..…….. Pejabat / *Office* : ……..……

Telefon Bimbit / *Handphone* : ……..……..

Alamat Emel / *Email Address*: ……...

Bagaimana anda tahu tentang unit ini? / *How do you know about this unit?* (Please tick in appropriate column)

☐	Sekolah / *School*	☐	Klinik Swasta / *General Practitioners (GP)*
☐	Kawan / *Friends*	☐	Media elektronik / *Electronic media* (TV, radio)
☐	Media masa / *Mass media* (magazine/book/etc)	☐	Lain-lain (nyatakan) / *Others (please state)* ……..…

Butir-butir ini diambil oleh / *These particulars was taken by*:

Nama Staf / *Name of Staff*: ……...

Jawatan / *Designation* : ……...

(Sila lihat muka surat sebelah / *Please turn over to the next page*)

ACTION(S) TAKEN BY STAFF

Appointment dates arranged by: ……

Appointment date: ……

IQ test date: ……

Individual assessment date: ……

Others:

……..

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