MOH/P/BPTK/26.26(GU) - e

Ministry of Health Malaysia

GUIDELINES FOR COLLABORATION BETWEEN THE MINISTRY OF HEALTH MALAYSIA (MOH) AND THE UNIVERSITI TUNKU ABDUL RAHMAN (UTAR) TRADITIONAL AND COMPLEMENTARY MEDICINE (T&CM) CENTRE ON THE PROVISION OF T&CM SERVICES

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This guideline shall be read in conjunction with the applicable laws, regulations, and relevant policies or guidelines currently in force, including but not limited to those listed in the references section.

CONTENT

			Page
LIST OF ABBREVIATIONS			4
1.	BACKGROUND		
	1.1.	COLLABORATION BETWEEN MOH AND UTAR T&CM CENTRE	5
	1.2.	OBJECTIVES OF COLLABORATION	5
2.	OBJECTIVES OF THE GUIDELINE		5
3.	PROVISION OF T&CM SERVICES BY UTAR T&CM CENTRE		
	3.1.	POLICIES	6
	3.2.	OPERATING HOURS	6
	3.3.	T&CM SERVICES	7
	3.4.	FEEDBACK OR COMPLAINT MANAGEMENT	7
	3.5.	SAFETY, ADVERSE EVENT, AND INCIDENT REPORTING	8
	3.6.	PATIENTS SELECTION	8
	3.7.	DOCUMENTATION AND RECORD KEEPING	8
	3.8.	REPORTING	9
	3.9.	MONITORING AND EVALUATION	9
4.	ROLES AND RESPONSIBILITIES		
	4.1.	MOH	9
	4.2.	UTAR T&CM CENTRE	11
5.	WORKFLOW		
	5.1.	WORKFLOW FOR T&CM SERVICE PROVISION	12
	5.2.	WORKFLOW FOR REFERRAL TO UTAR HOSPITAL FOR NON-EMERGENCY CASES	17
	5.3.	WORKFLOW FOR REFERRAL TO UTAR HOSPITAL FOR EMERGENCY CASES	20
	5.4.	WORKFLOW FOR INCIDENT REPORTING (CLINICAL/ NON-CLINICAL)	23
	5.5.	WORKFLOW FOR FEEDBACK OR COMPLAINT MANAGEMENT	26
APPENDIX			
A	LIST OF MOH HOSPITALS WITH T&CM SERVICES		28
B	FEE SCHEDULE FOR T&CM SERVICES AT UTAR T&CM CENTRE		29
C	LIST OF T&CM PRACTITIONERS AT UTAR T&CM CENTRE		32
D	CONSENT FOR CARE EXTENSION TO T&CM SERVICES FORM		35
E	CARE EXTENSION TO T&CM SERVICES FORM		37

F1	**UTAR T&CM CENTRE OUTPATIENT TREATMENT CONSENT FOR TCM, AYURVEDA AND TRADITIONAL MALAY TREATMENT**	39
F2	**UTAR T&CM CENTRE AYURVEDA TREATMENT CONSENT FORM**	41
F3	**UTAR T&CM CENTRE TRADITIONAL CHINESE MEDICINE TREATMENT CONSENT FORM**	43
G	**UTAR T&CM CENTRE T&CM ADMISSION FORM**	45
H	**UTAR T&CM CENTRE HEALTH QUESTIONNAIRE**	46
I	**UTAR T&CM CENTRE PATIENTS' OWN MEDICINES (POM) FORM**	49
J	**EVALUATION REPORT OF PATIENTS NOT SUITABLE TO RECEIVE T&CM SERVICES AT UTAR T&CM CENTRE**	50
K	**EVALUATION REPORT OF PATIENTS RECEIVING T&CM SERVICES AT UTAR T&CM CENTRE**	52
L	**UTAR T&CM CENTRE ASSESSMENT FOR PATIENT EMERGENCY OR URGENT ILLNESS (AEU)**	56
M	**UTAR T&CM CENTRE REFUSAL FOR REFERRAL/ PROCEDURE/ TREATMENT**	59
N	**UTAR HOSPITAL INCIDENT AND ACCIDENT REPORT**	61
O	**UTAR HOSPITAL PATIENT FEEDBACK FORM**	68
ACKNOWLEDGEMENT		70
EDITORS		71

LIST OF ABBREVIATIONS

COO	Chief Operating Officer
ED	Emergency Department
MOH	Ministry of Health Malaysia
PC	Practising Certificate
POM	Patient’s Own Medicine
QA	Quality Assurance
RMP	Registered Medical Practitioner
SHD	State Health Department
SOP	Standard Operating Procedure
TCM	Traditional Chinese Medicine
TIM	Traditional Indian Medicine
TMM	Traditional Malay Medicine
TPC	Temporary Practising Certificate
T&CM	Traditional and Complementary Medicine
UTAR	Universiti Tunku Abdul Rahman

1. BACKGROUND

1.1. COLLABORATION BETWEEN MOH AND UTAR T&CM CENTRE

According to the National Policy of Traditional and Complementary Medicine (T&CM) (second revision, 2007), T&CM is recognised as an integral part of the healthcare system, coexisting with Western medicine to enhance the health and quality of life of all Malaysians.

As of 2026, only 16 MOH hospitals in Malaysia offer selected T&CM services (**Appendix A**). Several states, including Perak, Perlis, and the Federal Territory of Labuan, do not have an MOH hospital providing such services. To improve accessibility and affordability, the MOH has collaborated with Universiti Tunku Abdul Rahman (UTAR) T&CM Centre in Kampar, Perak, to extend these services to MOH patients.

This collaboration aims to establish a structured referral mechanism, enabling MOH patients to receive T&CM services at UTAR T&CM Centre at a discounted rate, thereby easing their financial burden. Additionally, it seeks to foster mutual understanding and enhance communication between T&CM and Western medicine practitioners.

In the long run, this partnership is expected to strengthen the healthcare system by promoting a holistic approach to patient care, improving access to quality healthcare services, and bridging gaps in resources, expertise, and accessibility, particularly for the Perak community.

1.2. OBJECTIVES OF COLLABORATION

1.2.1. To enhance accessibility to safe and quality T&CM services for MOH patients, particularly in states without MOH facilities offering such services.

1.2.2. To foster communication and mutual understanding between T&CM and Western medicine practitioners.

2. OBJECTIVES OF THE GUIDELINE

To outline the mechanism and detailed workflow for the provision of T&CM services by UTAR T&CM Centre to MOH patients.

3. PROVISION OF T&CM SERVICES BY UTAR T&CM CENTRE

3.1. POLICIES

3.1.1. UTAR T&CM Centre shall be responsible for providing T&CM services at its facility.

3.1.2. Referral or care extension for T&CM services shall be provided by a Registered Medical Practitioner (RMP) from any MOH facility, in accordance with the established workflow (refer to Section 5.1).

3.1.3. Patients referred from MOH facilities have the autonomy to accept or decline T&CM services from UTAR T&CM Centre at any time.

3.1.4. UTAR T&CM Centre shall offer discounted rates to patients referred by MOH.

3.1.5. Patients shall be responsible for the payment of T&CM services received at UTAR T&CM Centre, as per the fee schedule (**Appendix B**).

3.1.6. T&CM services shall be provided by registered T&CM practitioners under the T&CM Act 2016 [Act 775], holding a valid Practising Certificate (PC) or Temporary Practising Certificate (TPC), and professional indemnity insurance.

3.1.7. UTAR T&CM Centre shall provide MOH with an updated list of T&CM practitioners involved in this collaboration from time to time (**Appendix C**).

3.2. OPERATING HOURS

The T&CM services will be provided by UTAR T&CM Centre during their operating hours as below:

Monday – Saturday	8.30am – 5.30pm
Sunday & Public Holiday	Closed

*Lunch break (1.00pm – 2.00pm)

3.3. T&CM SERVICES

3.3.1. The T&CM services provided at UTAR T&CM Centre shall fall under one of the recognised practice areas as stipulated in the T&CM (Recognised Practice Areas) Order 2017.

3.3.2. The following T&CM services will be provided at UTAR T&CM Centre (subject to any changes in the services offered by UTAR T&CM Centre):

Traditional Chinese Medicine (TCM)
- Acupuncture
- Herbal Medicine
- Tuina
- TCM Rehabilitation

Traditional Indian Medicine (TIM)
- Ayurveda

Traditional Malay Medicine (TMM)
- Malay Massage
- Postnatal Care

3.3.3. The treatment regimen and follow-up for T&CM services shall adhere to UTAR T&CM Centre's current guidelines and standard operating procedures (SOPs), based on patients' individual needs and conditions.

3.4. FEEDBACK OR COMPLAINT MANAGEMENT

3.4.1. Patients may provide feedback or lodge complaints regarding the T&CM services received at UTAR T&CM Centre.

3.4.2. UTAR T&CM Centre shall accept and manage patient feedback and complaints in accordance with the established workflow (refer to Section 5.5).

3.5. SAFETY, ADVERSE EVENT, AND INCIDENT REPORTING

3.5.1. Any adverse event or incident occurring during the provision of T&CM services shall be managed in accordance with the established workflow (refer to Section 5.4).

3.5.2. UTAR T&CM Centre shall document and report any contraindications, health issues, life-threatening/ adverse events, or complications arising from T&CM services to the MOH RMP.

3.6. PATIENTS SELECTION

3.6.1. T&CM services shall be offered to eligible patients by an MOH RMP from any MOH facility (hospital or clinic).

3.6.2. The MOH RMP shall obtain patient consent for the extension of care using the **CONSENT FOR CARE EXTENSION TO T&CM SERVICES FORM** (**Appendix D**).

3.6.3. Upon obtaining consent, the MOH RMP shall complete the **CARE EXTENSION TO T&CM SERVICES FORM** (**Appendix E**) to facilitate the referral.

3.6.4. Walk-in patients without a **CARE EXTENSION TO T&CM SERVICES FORM** signed by an MOH RMP shall be accepted as regular UTAR T&CM Centre patients.

3.7. DOCUMENTATION AND RECORD KEEPING

3.7.1. UTAR T&CM Centre shall maintain a register of all MOH patients receiving T&CM services.

3.7.2. UTAR T&CM Centre shall maintain a T&CM services record for every MOH patient who receives T&CM services.

3.7.3. All paper and digital documentation, including relevant forms, shall be kept in accordance with UTAR T&CM Centre’s medical record management policy.

3.7.4. MOH reserves the right to access all or part of the patient register and records upon request.

3.8. REPORTING

UTAR T&CM Centre shall compile, maintain and provide all relevant data, statistics, and reports as required by MOH for analysis, monitoring, and evaluation purposes.

3.9. MONITORING AND EVALUATION

UTAR T&CM Centre shall assist MOH in conducting monitoring and evaluation of T&CM services provided under this collaboration.

4. ROLES AND RESPONSIBILITIES

4.1. MOH

4.1.1. T&CM Division

a. To ensure that the collaboration between the MOH and the UTAR T&CM Centre aligns with relevant policies, acts and guidelines.

b. To oversee the overall implementation and assess the effectiveness of the collaboration.

4.1.2. State Health Department (SHD)

a. To facilitate communication between patients, MOH facilities, and UTAR T&CM Centre regarding service availability, patient rights and the seamless implementation of the referral process.

b. To promote mutual understanding and collaboration between T&CM and Western medicine practitioners to enhance patient care.

c. To coordinate and monitor the implementation of the collaboration at the state level, ensuring compliance with relevant policies, acts and guidelines.

d. To collect, review, and analyse data and reports provided by UTAR T&CM Centre on patient referrals, treatments, and outcomes.

e. To submit periodic reports to T&CM Division, MOH for evaluation of the collaboration's effectiveness.

4.1.3. RMP from MOH facility (hospital or clinic)

a. To assess and determine patient eligibility for T&CM services based on their medical condition and suitability.

b. To discuss potential benefits and limitations of T&CM services with the patient to ensure informed decision-making.

c. To adhere to relevant guidelines, policies, and ethical standards in facilitating the extension of T&CM services to the UTAR T&CM Centre.

d. To provide clear and relevant medical information in the referral form to ensure continuity of care.

e. To maintain open communication with UTAR T&CM practitioners regarding patient progress, contraindications, or any necessary modifications in treatment plans.

f. To educate patients about their rights and responsibilities regarding T&CM services, including treatment expectations, risks, and financial obligations.

g. To ensure patients understand that T&CM services are complementary and not a replacement for conventional medical treatment.

h. To ensure all referrals and patient interactions regarding T&CM services are properly documented in the patient's medical records.

i. To review patient progress and feedback from UTAR T&CM Centre and address any adverse events, complications, or concerns that arise during the patient's T&CM treatment.

j. To receive reports on contraindications, health issues, or adverse events from UTAR T&CM Centre and take appropriate medical action if a patient experiences complication due to T&CM treatment.

4.2. UTAR T&CM CENTRE

a. To ensure all administrative staff overseeing critical responsibilities are adequately trained and equipped with the required knowledge and skills to perform the given tasks.

b. To accept and provide T&CM services to patients referred from MOH hospitals and clinics through the **CARE EXTENSION TO T&CM SERVICES FORM** (**Appendix E**).

c. To ensure patients receive clear information about their treatment plan, expected outcomes, and any possible risks.

d. To allow patients to make an informed decision to continue or discontinue T&CM services at any time.

e. To ensure patients are aware of and responsible for paying the fees for T&CM services as per the fee schedule (**Appendix B**).

f. To comply with all medical, ethical, and legal requirements set by MOH and UTAR T&CM Centre.

g. To ensure patient safety by adhering to established guidelines and reporting mechanisms.

h. To regularly assess T&CM service effectiveness, patient outcomes, and areas for improvement.

i. To take necessary corrective actions to resolve issues and improve service quality.

5. WORKFLOW

5.1. WORKFLOW FOR T&CM SERVICE PROVISION

No.	Process	Action by	Forms
A. REFERRAL OR CARE EXTENSION (FROM ANY MOH FACILITY)			
1.	Obtain patient consent for care extension to T&CM services by completing the **CONSENT FOR CARE EXTENSION TO T&CM SERVICES FORM**. *For inquiries, UTAR T&CM Centre hotline (05-4620130) is available for both RMPs and patients at any time.*	MOH RMP	**Appendix D**
2.	Offer care extension to T&CM services to eligible patients by completing the **CARE EXTENSION TO T&CM SERVICES FORM**.	MOH RMP	**Appendix E**
3.	The referral documents are provided to the patient or their next of kin. Advise them to bring both forms to the UTAR T&CM Centre, or contact the centre directly to schedule an appointment (Tel: 05-4620130/ Email: u.tcmcentre@yahoo.com).	MOH RMP	**Appendix D and E**
B. APPOINTMENT SCHEDULING (BY UTAR T&CM CENTRE)			
4.	For patients who call to schedule an appointment, recommend an appropriate T&CM practitioner based on patient's chief complaint or allocate preferred T&CM practitioner (if applicable).	UTAR T&CM Centre	
5.	Arrange an appointment date based on availability of both the T&CM practitioner and the patient.	UTAR T&CM Centre	
C. PATIENT SCREENING (AT UTAR T&CM CENTRE)			
6.	Register the patient upon arrival with the completed and original copy of the **CONSENT FOR CARE EXTENSION TO T&CM SERVICES FORM** and **CARE EXTENSION TO T&CM SERVICES FORM**.	UTAR T&CM Centre	**Appendix D and E**
7.	Screen the patient for: • vital signs; • indications and contraindications; • suitability for receiving T&CM services; and	UTAR T&CM Centre	

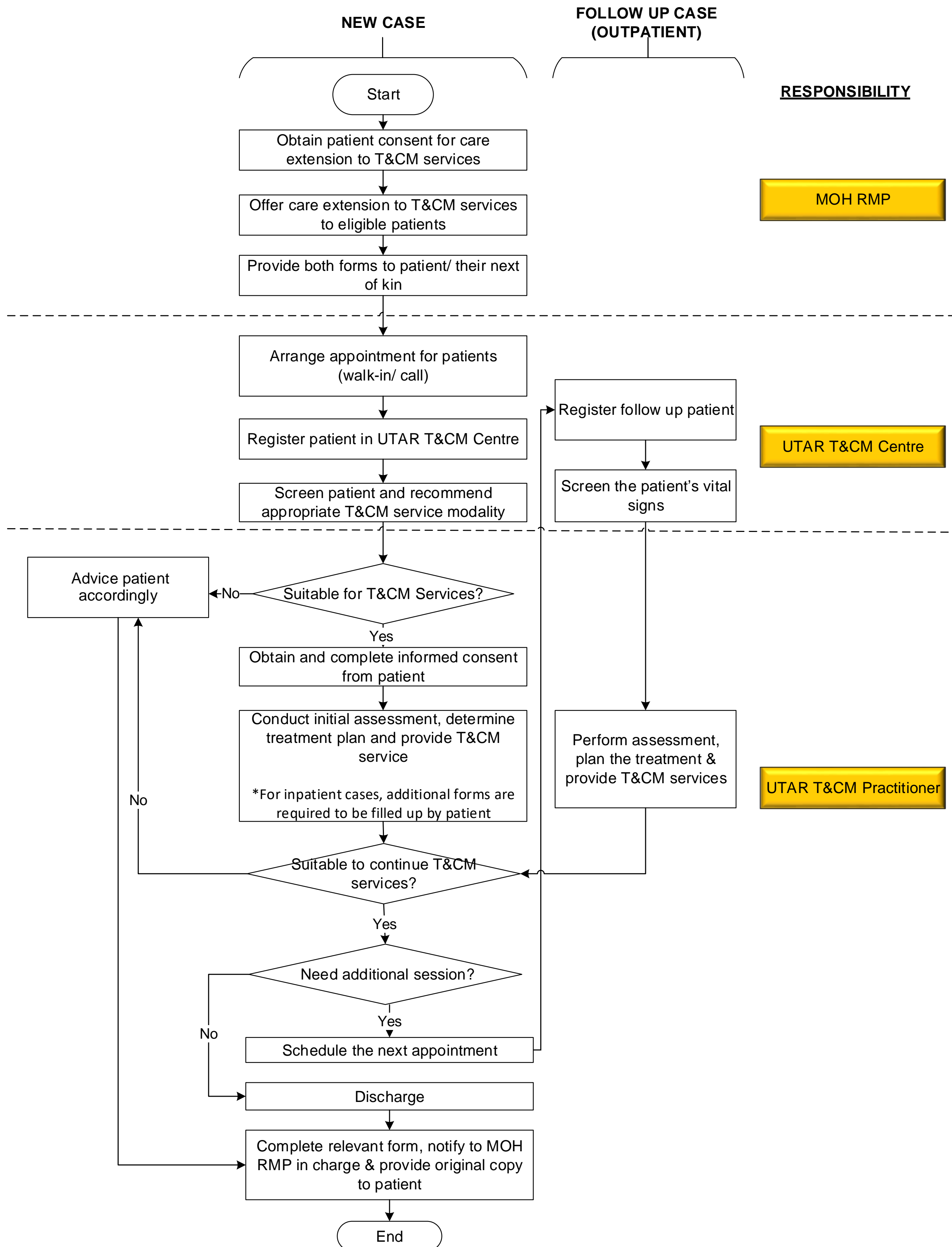
No.	Process	Action by	Forms
	• recommend appropriate T&CM service modality (outpatient or inpatient).		
8.	If patient is unsuitable for T&CM services: • advise the patient accordingly; • notify the MOH RMP in charge by providing a completed **EVALUATION REPORT OF PATIENTS NOT SUITABLE TO RECEIVE T&CM SERVICES AT UTAR T&CM CENTRE** via email; and • provide the original copy to the patient to pass back to the MOH RMP in charge. If suitable, proceed to Step No. 10.	UTAR T&CM Centre	**Appendix J**
D. SERVICE PROVISION (AT UTAR T&CM CENTRE)			
9.	Obtain informed consent by completing the UTAR T&CM CENTRE consent form for respective T&CM services: • Outpatient • Inpatient (Ayurveda) • Inpatient (TCM)	UTAR T&CM Practitioner	**Appendix** **F1** **F2** **F3**
10.	Conduct an initial assessment, determine the treatment plan, and provide the prescribed T&CM services. *For inpatient cases (without critical or severe conditions), patients must also complete: • **UTAR T&CM CENTRE T&CM ADMISSION FORM;** • **UTAR T&CM CENTRE HEALTH QUESTIONNAIRE**; and • **UTAR T&CM CENTRE PATIENTS' OWN MEDICINES (POM) FORM**.	UTAR T&CM Practitioner	**Appendix** **G** **H** **I**
11.	If patient is found unsuitable or unwilling to proceed with T&CM services: • advise the patient accordingly; • notify the MOH RMP in charge by providing a completed **EVALUATION REPORT OF PATIENTS NOT SUITABLE TO RECEIVE T&CM SERVICES AT UTAR T&CM CENTRE** via email; and • provide the original copy to the patient to pass back to the MOH RMP in charge.	UTAR T&CM Practitioner	**Appendix J**

No.	Process	Action by	Forms
	If suitable, proceed to Step No. 13.		
12.	Schedule the next appointment according to the prescribed treatment plan.	UTAR T&CM Centre	
E. FOLLOW-UP SERVICES FOR OUTPATIENTS (AT UTAR T&CM CENTRE)			
13.	Register follow-up patients with a valid appointment.	UTAR T&CM Centre	
14.	Screen the patient's vital signs.	UTAR T&CM Centre	
15.	Perform a follow-up assessment, determine the treatment plan, and provide the prescribed T&CM services.	UTAR T&CM Practitioner	
16.	If the patient is found unsuitable to continue T&CM services: • advise the patient accordingly; • notify the MOH RMP in charge by providing a completed **EVALUATION REPORT OF PATIENTS NOT SUITABLE TO RECEIVE T&CM SERVICES AT UTAR T&CM CENTRE** via email; and • provide the original copy to the patient to pass back to the MOH RMP in charge. If suitable, proceed to Step No. 18.	UTAR T&CM Practitioner	**Appendix J**
F. DISCHARGE			
17.	Discharge the patient upon completion of one cycle of the T&CM treatment regime: • notify the MOH RMP in charge by providing a completed **EVALUATION REPORT OF PATIENTS RECEIVING T&CM SERVICES AT UTAR T&CM CENTRE** via email; and • provide the original copy to the patient to pass back to the MOH RMP in charge or UTAR T&CM Centre to email back to the respective MOH RMP within two (2) weeks from the date of discharge.	UTAR T&CM Practitioner	**Appendix K**
18.	If the MOH RMP determines that another T&CM treatment cycle is beneficial, repeat the process starting from Step No. 1.	MOH RMP	

Note:

1. Patients who fail to attend their scheduled follow-up appointment or do not contact UTAR T&CM Centre to reschedule within one (1) month from the appointment date shall be considered as having defaulted on their T&CM services.

2. If the patient is still interested in receiving T&CM services at UTAR T&CM Centre, they must obtain a new and completed **CONSENT FOR CARE EXTENSION TO T&CM SERVICES FORM** and **CARE EXTENSION TO T&CM SERVICES FORM** from an MOH RMP before resuming treatment.

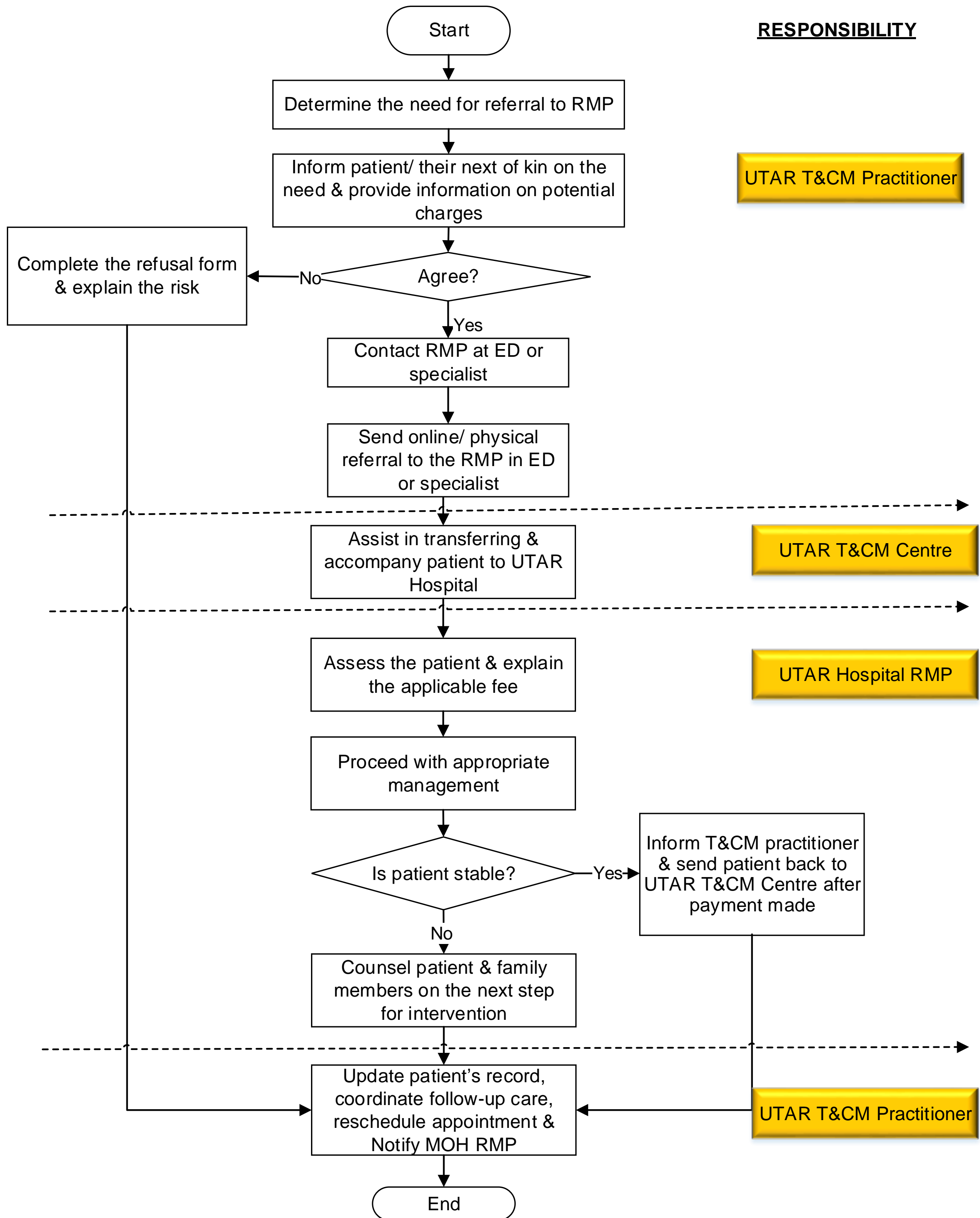

WORKFLOW FOR T&CM SERVICE PROVISION
NEW CASE
FOLLOW UP CASE (OUTPATIENT)
RESPONSIBILITY
Start
Obtain patient consent for care extension to T&CM services
Offer care extension to T&CM services to eligible patients
Provide both forms to patient/ their next of kin
MOH RMP
Arrange appointment for patients (walk-in/ call)
Register patient in UTAR T&CM Centre
Screen patient and recommend appropriate T&CM service modality
Register follow up patient
Screen the patient's vital signs
UTAR T&CM Centre
Advice patient accordingly
No
Suitable for T&CM Services?
Yes
Obtain and complete informed consent from patient
Conduct initial assessment, determine treatment plan and provide T&CM service
*For inpatient cases, additional forms are required to be filled up by patient
Perform assessment, plan the treatment & provide T&CM services
UTAR T&CM Practitioner
No
Suitable to continue T&CM services?
Yes
Need additional session?
No
Yes
Schedule the next appointment
Discharge
Complete relevant form, notify to MOH RMP in charge & provide original copy to patient
End

5.2. WORKFLOW FOR REFERRAL TO UTAR HOSPITAL FOR NON-EMERGENCY CASES

No	Process	Action by	Forms
1.	If a T&CM practitioner determines that the patient requires referral to the RMP, the patient shall be referred to the UTAR Hospital following UTAR Hospital Policy.	UTAR T&CM Practitioner	
2.	The T&CM practitioner shall inform the patient or their next of kin on the need for referral and provide information on potential charges for investigations or treatments.	UTAR T&CM Practitioner	
3.	If the patient or their next of kin agrees, the T&CM practitioner shall contact the RMP at the Emergency Department (ED) or the relevant specialist via phone.	UTAR T&CM Practitioner	
4.	If the patient/ their next-of-kin disagrees, the following steps must be taken by the T&CM practitioner: • **Completion of Refusal Form** The patient or next of kin must be requested to complete the **UTAR T&CM CENTRE REFUSAL FOR REFERRAL/ PROCEDURE/ TREATMENT** form. • **Explanation of Risks** The T&CM practitioner must clearly explain the potential clinical risks that may arise from refusing the referral, procedure, or recommended treatment. • **Documentation of Refusal** This refusal must be thoroughly documented in the patient's medical record. • **Notification to MOH RMP** The T&CM practitioner must notify the original referring MOH RMP of the patient's decision to ensure proper documentation and to facilitate any necessary follow-up actions.	UTAR T&CM Practitioner	**Appendix M**
5.	An online or physical referral letter shall be sent to the designated RMP.	UTAR T&CM Practitioner	
6.	UTAR T&CM Centre staff shall assist in transferring the patient to the UTAR Hospital,	UTAR T&CM Centre	

No	Process	Action by	Forms
	ensuring that the patient is accompanied by a staff if required.		
7.	The RMP shall assess the patient, explain the applicable fees, proceed with appropriate medical management based on the patient's condition or refer patient to another medical facility if required.	UTAR Hospital RMP	
8.	If the patient's condition is stable and does not require further intervention, the RMP shall inform the T&CM practitioner and send the patient back to the UTAR T&CM Centre after payment has been made.	UTAR Hospital RMP	
9.	If further intervention is required, the RMP shall counsel the patient and family members on the next steps and necessary procedures.	UTAR Hospital RMP	
10.	The T&CM practitioner shall update the patient's records accordingly and coordinate with the UTAR Hospital RMP for any necessary follow-up care and rescheduling T&CM appointment. The T&CM practitioner shall also notify MOH RMP.	UTAR T&CM Practitioner	

WORKFLOW FOR REFERRAL TO UTAR HOSPITAL FOR NON EMERGENCY CASES

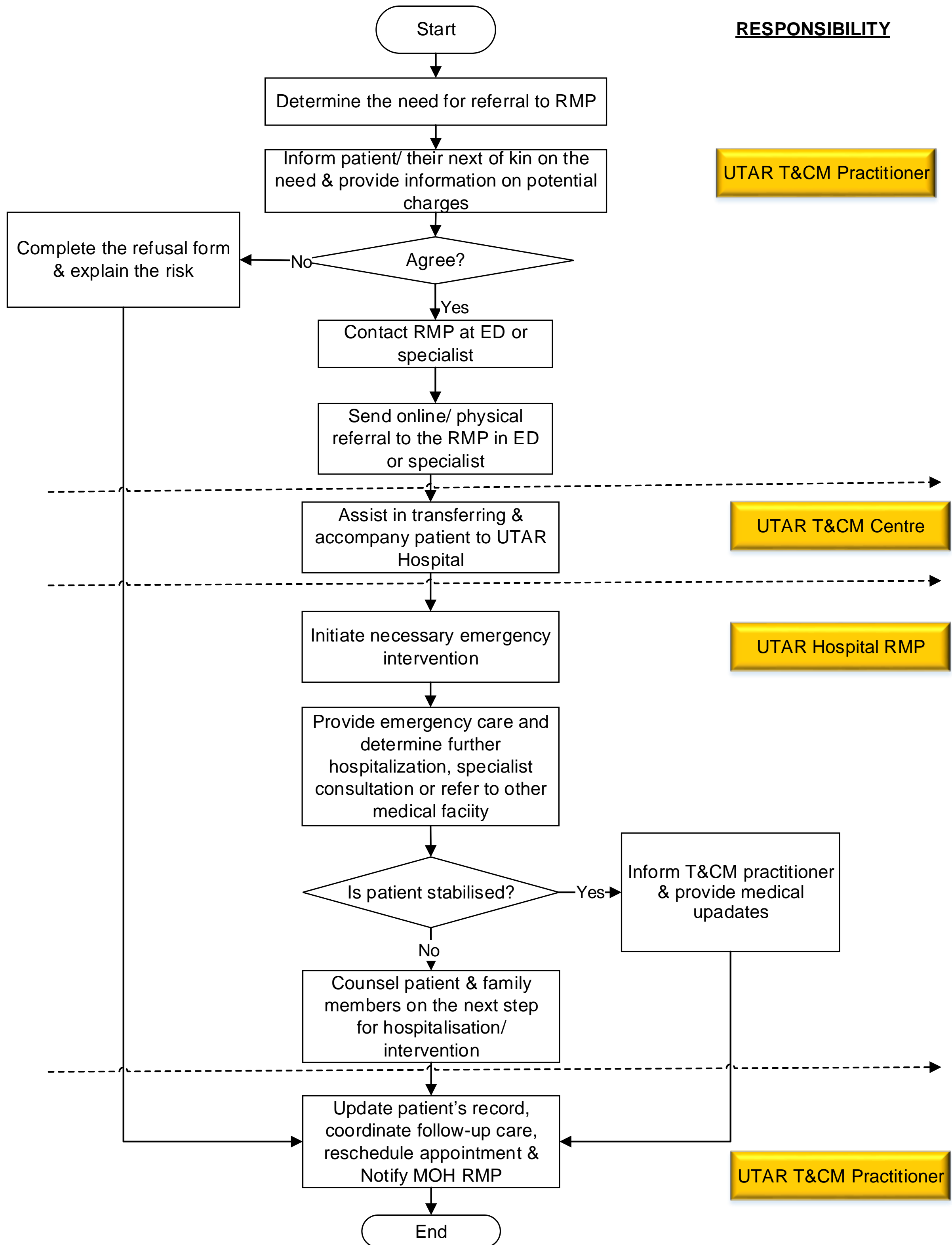


5.3. WORKFLOW FOR REFERRAL TO UTAR HOSPITAL FOR EMERGENCY CASES

No	Process	Action by	Forms
1.	If a T&CM practitioner determines that the patient is experiencing a medical emergency, patient will be assessed using **UTAR T&CM CENTRE ASSESSMENT FOR PATIENT EMERGENCY OR URGENT ILLNESS (AEU)** document**.** Any immediate referral to the UTAR Hospital shall be initiated in accordance with UTAR Hospital Policy. The verbal or implied consent may be assumed if the patient is incapacitated and no next-of-kin is immediately available.	UTAR T&CM Practitioner	**Appendix L**
2.	However, if the patient/ their next of kin disagrees, the following steps must be taken by the T&CM practitioner: • **Completion of Refusal Form** The patient (provided they are fully conscious and able to make informed decisions) or next of kin must be requested to complete the **UTAR T&CM CENTRE REFUSAL FOR REFERRAL/ PROCEDURE/ TREATMENT** form. • **Explanation of Risks** The T&CM practitioner must clearly explain the potential clinical risks that may arise from refusing the referral, procedure, or recommended treatment. • **Documentation of Refusal** This refusal must be thoroughly documented in the patient's medical record. • **Notification to MOH RMP** The T&CM practitioner must notify the original referring MOH RMP of the patient's decision to ensure proper documentation and to facilitate any necessary follow-up actions.	UTAR T&CM Practitioner	**Appendix M**
3.	The T&CM practitioner shall stabilise the patient as per their professional scope while promptly contacting the Emergency Department (ED) for emergency management.	UTAR T&CM Practitioner	

No	Process	Action by	Forms
4.	A verbal referral shall be made immediately via phone to the RMP at the ED, followed by a written referral letter (physical or online).	UTAR T&CM Practitioner	
5.	UTAR T&CM Centre staff shall assist in transferring the patient to the ED, ensuring that the patient is accompanied by a staff if required.	UTAR T&CM Centre	
6.	Upon arrival at the ED, the RMP shall take over patient management and initiate necessary emergency interventions.	UTAR Hospital RMP	
7.	The RMP shall provide emergency care and determine if further hospitalisation, specialist consultation or refer to another medical facility is required.	UTAR Hospital RMP	
8.	If the patient is stabilised and deemed fit for discharge, the RMP shall inform the T&CM practitioner and provide relevant medical updates.	UTAR Hospital RMP	
9.	If hospitalisation or further intervention is required, the RMP shall counsel the patient and family members on the next steps and necessary medical procedures.	UTAR Hospital RMP	
10.	The T&CM practitioner shall update the patient's records accordingly and coordinate with the UTAR Hospital RMP for any necessary follow-up care and rescheduling T&CM appointment. The T&CM practitioner shall also notify MOH RMP.	UTAR T&CM Practitioner	

WORKFLOW FOR REFERRAL TO UTAR HOSPITAL FOR EMERGENCY CASES



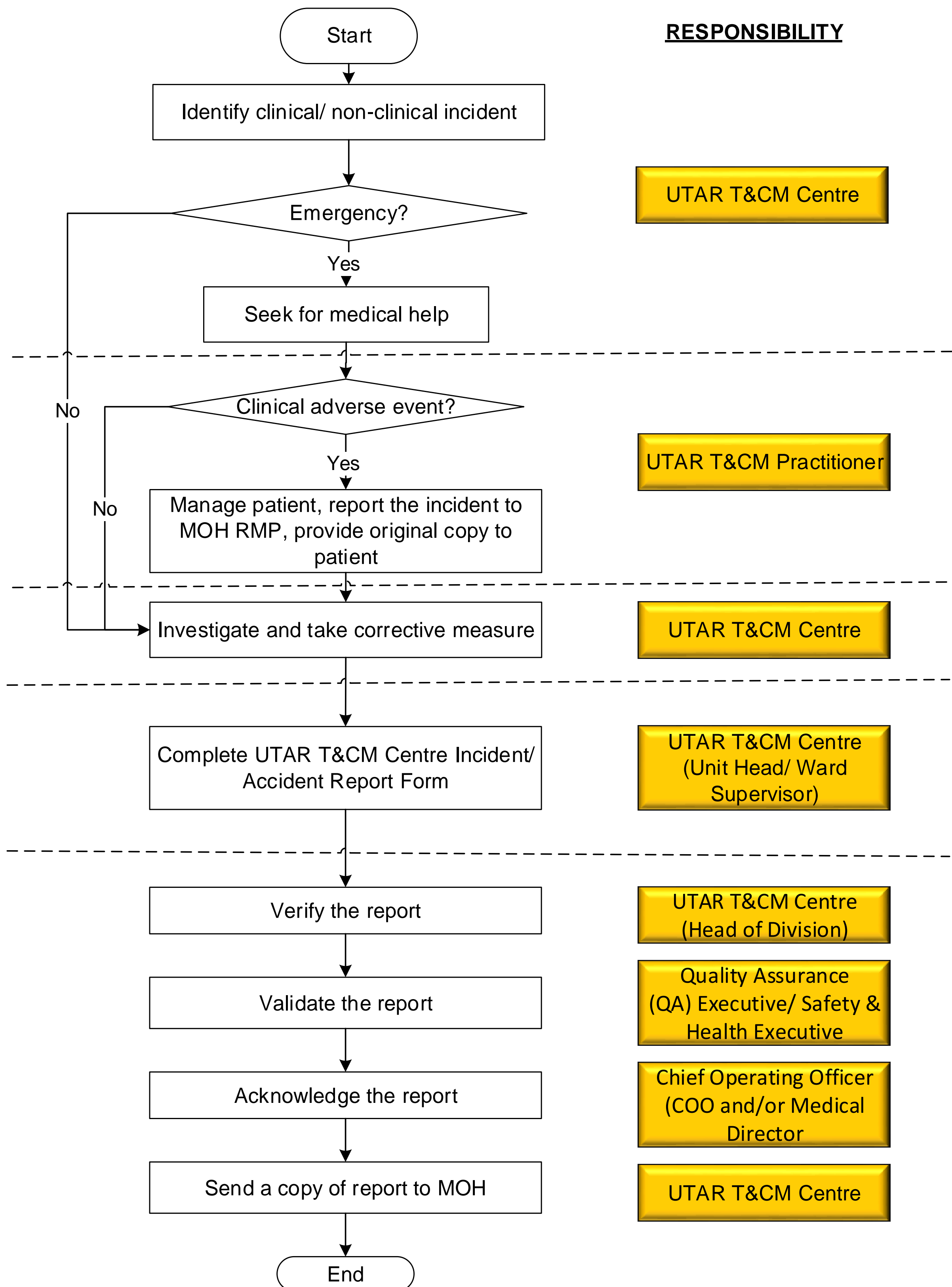
5.4. WORKFLOW FOR INCIDENT REPORTING (CLINICAL/ NON-CLINICAL)

No	Process	Action by	Forms
1.	Identify any clinical or non-clinical incident occurring during or after receiving T&CM services.	UTAR T&CM Centre	
2.	Seek immediate assistance, if necessary: • if the incident is an emergency, seek medical help immediately. • ensure patient safety and provide first aid if applicable.	UTAR T&CM Centre	
3.	If incident involves a clinical adverse event: • manage the patient accordingly; • report the incident to the MOH RMP in charge by providing a completed **EVALUATION REPORT OF PATIENTS RECEIVING T&CM SERVICE AT UTAR T&CM CENTER** via email; and • provide the original copy to the patient to pass back to the MOH RMP in charge.	UTAR T&CM Practitioner	**Appendix K**
4.	Conduct an investigation to determine the cause of the incident. Take appropriate corrective measures to prevent recurrence.	UTAR T&CM Centre	
5.	Complete the **UTAR HOSPITAL INCIDENT AND ACCIDENT REPORT** form in accordance with the UTAR T&CM Centre Policy.	UTAR T&CM Centre (Unit Head/ Ward Supervisor)	**Appendix N**
6.	Verify the report.	UTAR T&CM Centre (Head of Division)	
7.	Validate the report.	Quality Assurance (QA) Executive/ Safety and Health Executive	
8.	Acknowledge the report.	Chief Operating Officer (COO) and/or Medical Director	
9.	Send a copy of the incident report to MOH for review and further action if necessary.	UTAR T&CM Centre	

Note:

1. A patient who has experienced a clinical incident (adverse event) due to T&CM services must obtain a new and completed **CONSENT FOR CARE EXTENSION TO T&CM SERVICES FORM** and **CARE EXTENSION TO T&CM SERVICES FORM** from an MOH RMP if they wish to continue receiving T&CM services at UTAR T&CM Centre after the adverse event has been resolved.

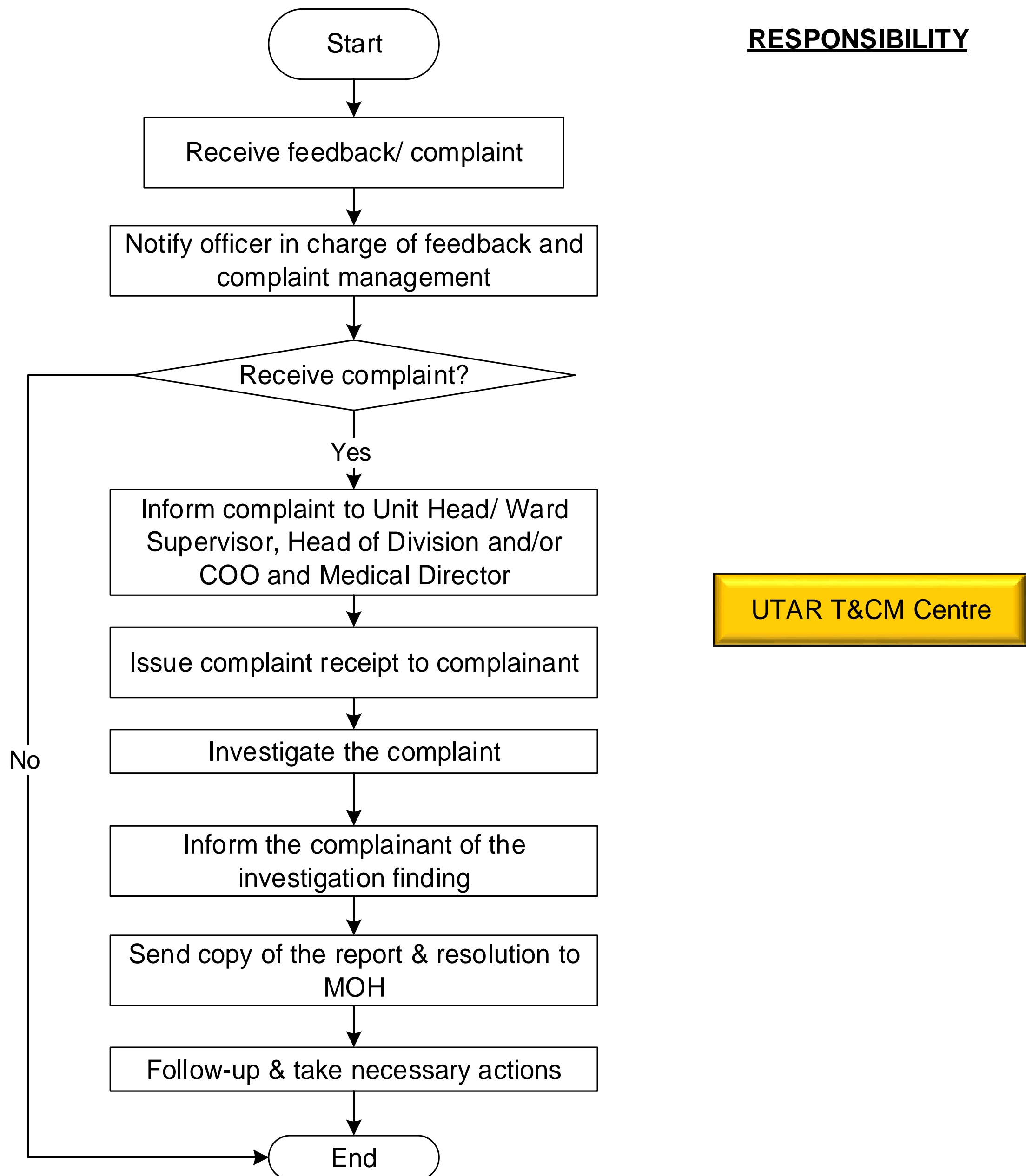
WORKFLOW FOR INCIDENT REPORTING (CLINICAL/ NON-CLINICAL)



5.5. WORKFLOW FOR FEEDBACK OR COMPLAINT MANAGEMENT

No	Process	Action by	Forms
1.	Receive feedback or complaint from patient regarding T&CM services received at UTAR T&CM Centre.	UTAR T&CM Centre	**Appendix O**
2.	Notify the officer responsible for feedback and complaint management.	UTAR T&CM Centre	
3.	If a complaint is received, notify the following personnel: • Unit Head/ Ward Supervisor; • Head of Division; • Chief Operating Officer (COO) and/or Medical Director.	UTAR T&CM Centre	
4.	Issue a complaint receipt to complainant within the duration specified by UTAR T&CM Centre Policy.	UTAR T&CM Centre	
5.	Conduct an investigate into the complaint within the duration specified by UTAR T&CM Centre Policy.	UTAR T&CM Centre	
6.	Inform the complainant of the investigation findings and resolution within the duration specified by UTAR T&CM Centre Policy.	UTAR T&CM Centre	
7.	Maintain proper documentation of the complaint, investigation, and resolution for record-keeping purposes. If the complaint involves MOH patients, send a copy of the complaint report and resolution to MOH for review and further action if necessary.	UTAR T&CM Centre	
8.	If additional investigation is required, follow up accordingly and take necessary actions to prevent recurrence.	UTAR T&CM Centre	

WORKFLOW FOR FEEDBACK OR COMPLAINT MANAGEMENT



Appendix A

LIST OF MOH HOSPITALS WITH T&CM SERVICES

State	MOH Hospital (16)	T&CM Services offered
Perlis	-	-
Kedah	Hospital Sultanah Bahiyah	Acupuncture, Traditional Massage
Pulau Pinang	Hospital Kepala Batas	Acupuncture, Traditional Massage, Herbal Therapy
Perak	-	-
Selangor	Hospital Selayang	Acupuncture, Traditional Massage
	Hospital Sungai Buloh	Varmam Therapy*
Kuala Lumpur/ Putrajaya	Institut Kanser Negara	Acupuncture, Herbal Therapy
	Hospital Putrajaya	Acupuncture, Traditional Massage
	Hospital Rehabilitasi Cheras	Acupuncture, Traditional Massage, Shirodhara*, External Basti Therapy*
Negeri Sembilan	Hospital Port Dickson	Acupuncture, Traditional Massage, Shirodhara*, External Basti Therapy*
Melaka	Hospital Jasin	Acupuncture, Traditional Massage
Johor	Hospital Sultan Ismail	Acupuncture, Traditional Massage, Herbal Therapy
Pahang	Hospital Pekan	Traditional Massage
Terengganu	Hospital Sultanah Nur Zahirah	Acupuncture, Traditional Massage
Kelantan	Hospital Raja Perempuan Zainab II	Acupuncture, Traditional Massage
Sabah	Hospital Wanita & Kanak-Kanak Likas	Acupuncture, Traditional Massage, Herbal Therapy
	Hospital Duchess of Kent	Acupuncture, Traditional Massage
Sarawak	Hospital Umum Sarawak	Acupuncture, Traditional Massage
Labuan	-	-

*Currently not available.

Appendix B

FEE SCHEDULE FOR T&CM SERVICES AT UTAR T&CM CENTRE

(Subject to changes based on services and fees offered at UTAR T&CM Centre)

A. CONSULTATION FEE (PER SESSION)

i) General (except for Acupuncture and Tuina)

No.	Practitioner	Regular Patients (RM)	MOH Referral Patients (RM)
1.	T&CM Practitioner	15	8
2.	Senior T&CM Practitioner*	20	12
3.	Principal T&CM Practitioner**	25	16

ii) Acupuncture and Tuina

No.	Practitioner	Regular Patients (RM)		MOH Referral Patients (RM)	
		1st session	Follow-up session	1st session	Follow-up session
1.	T&CM Practitioner	15	15	8	8
2.	Senior T&CM Practitioner*	20	15	12	12
3.	Principal T&CM Practitioner**	25	20	16	16

Practitioner with Master* or PhD** qualification in a relevant T&CM field and/or equivalent clinical experience.

B. TREATMENT FEE (PER SESSION)

i) Traditional Chinese Medicine (TCM)

No.	Treatment	Regular/ MOH Referral Patients (RM)
1.	Herbal medicine	60 – 100 (for 5 days)
2.	Tuina	45
3.	Acupuncture	35
4.	Moxibustion	10
5.	Cupping	10
6.	Scrubbing	10

*Additional RM10 for the 5-day herbal medicine decoction fee (代煎) (optional).

ii) TCM Rehabilitation

No.	Treatment	Regular/ MOH Referral Patients (RM)
1.	Cupping	10
2.	Healthcare Gua Sha (Scrubbing)	20
3.	Facial Gua Sha (Scrubbing)	30
4.	Fire-Dragon Moxibustion (HuoLongJiu)	40
5.	Thunder-Fire Moxibustion (LeiHuoJiu)	30
6.	FuYangGuan	30
7.	Herbal Body Bath	25
8.	Herbal Foot Bath	20
9.	L.A.E. Sauna	20
10.	TCM Electrotherapy	20
11.	TCM Fumigation	20
12.	TCM Thermotherapy	20
13.	Rehab Acupuncture	20
14.	Rehab Exercise	20
15.	Rehab Moxibustion	20
16.	Rehab Traction	20
17.	Rehab Tuina	25

iii) Ayurveda

No.	Treatment	Regular/ MOH Referral Patients (RM)
1.	Ayurveda medicine (oral medicine and/or medicated oil)	120 – 170 (for 5 days)
2.	Oil treatment	
	a) *Kabalam, Matra Vasti, Kadi Vasti, Janu Vasti, Greeva Vasti, Nethradhara, Local Pizichil, Local Podikizhi, Local Njavara, Thalapodichil, Utharavasti, Virechanam, Nasyam, Tharpanam, Lepam, Thalam, Pichu, Facial, Vamanam*	20
	b) *Abhayangam, Pizichil, Podikizhi, Ela kizhi, Njavara kizhi, Sirodhara, Dhanyamaladhara, Sirovasti, Kashaya Vasti, Udwardhanam, Thakradhara, Kashaya dhara, Kheeradhara*	40
	c) *Dinacharya, Chavittiuzhichil*	60

iv) Traditional Malay Medicine

No.	Treatment	Regular/ MOH Referral Patients (RM)
1.	*Medicated oil	60 – 120
2.	Treatment:	
	a) *Urutan Perubatan*	45
	b) *Tuam*	20
	c) *Tungku*	20

*Medicated oil is charged separately from treatment services; with pricing determined by the specific product used.

C. INPATIENT SERVICES (PER DAY)

i) Room rates

No.	Room Type	Regular Patients (RM)	MOH Referral Patients (RM)
1.	Single Bed Room	180	180
2.	Double Bedded Room	110	100
3.	Four Bedded Room	80	70

ii) Nursing Care

No.	Care Level	Regular/ MOH Referral Patients (RM)
1.	Low	30
2.	Medium	40
3.	High	50
4.	Dependent	95

Note:

1. All fees are subject to change. Patients are advised to confirm with UTAR T&CM Centre before their appointment.

2. Same consultation and treatment fees apply for both outpatient and inpatient services.

Appendix C

LIST OF T&CM PRACTITIONERS AT UTAR T&CM CENTRE

中医内科 TCM Internal Medicine			
	医师 Practitioner	科系 Category	详情 Details
男 Male	拉曼大学传辅医疗中心总监 Director UTAR T&CM Centre 郑建强博士, 主任中医师 Dr. Te Kian Keong Principal TCM Practitioner 博士学位 南京中医药大学 PhD (TCM) NJUCM 仅限每周三 Every Wednesday ONLY	中医肿瘤问题 TCM Oncological Issues	肿瘤后问题等 Post-Oncological Issues, etc.
		中医杂病 TCM Miscellaneous Issues	疑难杂病等 Difficulty and miscellaneous Issues, etc.
男 Male	拉曼大学传辅医疗中心副总监 Deputy Director UTAR T&CM Centre 朱子贤, 主治中医师 Mr. Choo Zi Xian Senior TCM Practitioner 硕士学位 上海中医药大学 MMed (TCM) SHUTCM	中医骨、关节和肌肉疾病 TCM Bone, Joint & Muscle Issues	关节疼痛、肌肉痉挛、麻木、震颤、痿证，腰痛等 Joint pain, muscle spasm, numbness, tremor, atrophy, low back pain, etc.
		中医肿瘤问题 TCM Oncological Issues	肿瘤问题等 Oncological Issues
男 Male	传辅病房主任 T&CM Ward HOD 陈展庆, 主治中医师 Mr. Tan Chan Qing Senior TCM Practitioner 硕士学位 广州中医药大学 MMed (TCM) GZUCM	中医肺系疾病 TCM Fèi (Lungs) Issues	感冒、咳嗽、喘证、鼻血、咳血等 Common Cold, cough, short of breathness, nose bleeding, hemoptysis, etc.
		中医心系疾病 TCM Xīn (Heart) Issue	失眠、胸痛、胸闷、痴呆等 Insomnia, chest pain, chest tightness, dementia,etc.
		中医儿科疾病 TCM Pediatrics Issues	小儿 - 腹胀，腹泻，厌食，遗尿，夜啼，水肿等 Abdominal bloating, diarrhea, anorexia, nocturnal enuresis, sleep terror, edema, etc.
女 Female	伍惠仪, 中医师 Ms. Goh Wui Yee TCM Practitioner 学士学位 上海中医药大学 BMed (TCM) SHUTCM	中医妇科疾病 TCM Gynaecological Issues	月经失调、白带异常、更年期综合征、备孕、妇科炎症、乳腺疾病等、产后综合征 (月子) Menstrual, Leucorrhea, Menopausal, Birth Planning, Gynecological Inflammation, breast diseases, Postpartum Syndrome, etc

中医康复科 TCM Rehabilitation			
	医师 Practitioner	科系 Category	详情 Details
男 Male	中医康复中心主任 TCM Rehabilitation Centre HOD 于世超博士, 主任中医师 Dr. Yu, Shichao Principal TCM Practitioner 博士学位 拉曼大学 PhD (TCM) UTAR	中医皮肤、骨科、疼痛、疑难杂病 康复保健 TCM Skin, Bone, Pain, Misceallenous Rehabilitation & Health Care	难治性皮肤问题、骨科康复、疼痛管理、中医疑难杂病、中医食疗及药膳、老年保健与康复、助孕调理、失眠、中医特色康复 Skin Conditions Rehab, Orthopedic Rehabilitation, Pain Management, Complex Conditions in TCM, TCM Dietary Therapy and Herbal Cuisine, Geriatric Care and Rehabilitation, Birth Planning Support, Insomnia Rehab, TCM Rehab Service
女 Female	陈思縈, 中医师 Ms. Chin Shi Ying TCM Practitioner 学士学位 广州中医药大学 BMed (TCM) GZUCM	中医女性及儿童康复保健 TCM Female & Paediatric Rehabilitation & Health Care	产后康复、儿科、妇科、中医美容保健、内分泌管理、中医特色康复 Postpartum Rehabilitation, Pediatrics, Gynecology, TCM Aesthetic Care and Wellness, Endocrine Management, TCM Rehab Service
男 Male	丁裕骁, 中医师 Mr. Ting Yu Han (Alex) TCM Practitioner 学士学位 厦门大学 BMed (TCM) XMUM	中医运动与体态康复保健 TCM Sports & Exercise Rehabilitation & Health Care	亚健康、体态管理、运动康复、康复牵引、功法锻炼、中医特色康复 Sub-health Management, Postural Management, Exercise Rehabilitation, Traction Therapy, Therapeutic Exercises, TCM Rehab Service
中医特色康复包括：药浴、足浴、特色火龙灸、艾灸、中药熏蒸、刮痧、拔罐、LAE光能屋、牵引、腹部推拿、小儿推拿、脸部刮痧 TCM Rehab Service inclusive of: Herbal Body Bath, Herbal Foot Bath, Fire-Dragon Moxibustion, Moxibustion, Herbal Fumigation, Scrapping(Guasha), Facial Guasha, Cupping(Baguan), LAE, Traction, Abdominal TuiNa, Paedric TuiNa			

马来医疗 Malay Medicine			
	医师 Practitioner	科系 Category	详情 Details
男 Male	Dr. Wan Adnan Malay Medicine Practitioner SKM MD, Universiti Sains Malaysia	马来传统医疗推拿 Urutan Perubatan Medicinal Massage	身体疼痛、肌肉疼痛、身体疲倦、头疼、头晕、失眠、筋伤、脊柱侧弯等等 Muscle Ache, Physical Fatique, Headache, Dizziness, Insomnia, Muscle Strain, Scoliosis, etc
女 Female	Pn. Nor Liyana Malay Medicine Practitioner SKM III Urut Therapy Linton University College	马来传统医疗推拿 Urutan Perubatan Medicinal Massage	身体疼痛、肌肉疼痛、身体疲倦、头疼、头晕、失眠、筋伤、脊柱侧弯等等 Muscle Ache, Physical Fatique, Headache, Dizziness, Insomnia, Muscle Strain, Scoliosis, etc
		马来传统产后推拿 Urutan Post-Natal Post-Natal Massage	产后调理、母乳按摩、腹部按摩等等 Post-Natal, Body Ache, Lactation Massage, Abdominal Massage, etc

阿育吠陀 Ayurveda - Indian Medicine			
	医师 Practitioner	科系 Category	详情 Details
男 Male	Mr. Kochanattu Koickal Sajith Varma Principal Ayurveda Practitioner B.A.M.S. University of Madras	内科 Internal Issues	肌肉骨骼疾病，癌症手术、癌症放化疗、皮肤病、妇科疾病、排毒、老年医学、 神经系统疾病、儿科病症、呼吸系统疾病、肺系疾病、耳鼻喉科疾病、恢复等 Musculoskeletal issues, post surgery/ chemotherapy for cancer, rejuvenation, skin issues, gynaecological issues, neurological issues, paediatric condition, respiratory disorder, lungs condition, ENT disorder, geriatrics, detoxification, etc.
		上下肢体关节疾病 Limbs Disorder	下背部、臀部、腿部、膝盖、脚后跟肌肉骨骼疼痛、脚踝扭伤和运动损伤颈部、肩部、上肢关节疼痛、肩周炎、网球肘、扳机指等 Lower back, hip, legs, knees, heels musculoskeletal pain, ankle sprain, other sports injuries, Neck, shoulder, upper limbs, musculoskeletal pain, frozen shoulder, tennis elbow, trigger finger etc.
		妇科筋伤 Gynecological Musculoskeletal Issues	产后骨盆修复，经期腰痛，经期颈部疼痛，脊柱侧弯等 Postpartum pelvic rehabilitation, menstrual lower back pain, menstrual neck pain, scoliosis, etc.
		姿势问题 Body Posture Issues	脊柱侧弯、肩高低、驼背、长短腿等 Scoliosis, uneven shoulder, hunched back, pelvic tilt, etc.

心理辅导 Counselling			
	咨商师 / 辅导员 Counsellor	科系 Category	详情 Details
女 Female	吴佳容, 辅导员 Ms. Ngu Ka Yun Counsellor 硕士学位 国立台北护理健康大学 (国北护) MSc NTUNHS	心理辅导 Counselling	自我探索、人际关系、亲密关系、亲子关系、压力与情绪困扰、生涯探索、生活适应、学习问题、失落与悲伤、家庭议题、等等 Self-exploration, interpersonal relationship, intimate relationship, parent-child relationship, stress and emotional distress, career, life adaptation, learning issues, grief and loss, family issues, and others

推拿 Tuina			
	医师 Practitioner	科系 Category	详情 Details
男 Male	推拿科主任 Tui Na HOD 胡启旻, 主治中医师 Mr. Aw Chi Min Senior TCM Practitioner 硕士学位 广西中医药大学 MMed (TCM) GXUTM	中医骨伤科 TCM Orthopedics Issues	闭合单纯性骨折、脱位、骨折术后、脱位术后、习惯性脱位等 Closed simple fractures, dislocations, post-fracture surgery, post-dislocation surgery, and habitual dislocations, etc.
		中医姿势问题 TCM Body Posture Issues	脊柱侧弯、高低肩、驼背、长短腿等 Scoliosis, uneven shoulders, hunchback, pelvic tilt, etc.
女 Female	伍郡莹, 主治中医师 Ms. Ng Jun Ying Senior TCM Practitioner 硕士学位 广州中医药大学 MMed (TCM) GZUCM	中医上肢体关节疾病 Upper Limbs Disorder	颈部、肩部、上肢关节疼痛、肩周炎、网球肘、扳机指与运动损伤等 Neck, shoulder, upper limb joint pain, frozen shoulder, tennis elbow, trigger finger, sport upper limb injury etc.
		妇科筋伤 Gynecological Musculoskeletal Issues	产后骨盆修复，经期腰痛，经期颈部疼痛，脊柱侧弯等 Postpartum pelvic repair, menstrual low back pain, menstrual head and neck pain, scoliosis, etc.
男 Male	许伟恩, 中医师 Mr. David Koh Vui En TCM Practitioner 学士学位 厦门大学 BMed (TCM) XMUM	中医下肢体关节疾病 Lower Limbs Disorder	腰背部、臀部、腿部、膝盖、脚后跟肌肉骨骼疼痛，脚踝扭伤与运动损伤等 Musculoskeletal pain in the lower back, hips, legs, knees, heels, ankle sprains and lower limbs sports injuries.
男 Male	林颖聪, 中医师 Mr. Lim Ying Cong TCM Practitioner 学士学位 广州中医药大学 BMed (TCM) GZUCM	中医脑/神经病科 TCM Neurology Issues	中风后遗症、眩晕、肢体颤抖、肢体乏力、面痛、面瘫、面麻等。 Post-stroke treatment, dizziness, limb tremors, limb weakness, facial pain, facial paralysis, facial numbness, etc.

<table>
<tr><th colspan="4">针灸 Acupuncture</th></tr>
<tr><td rowspan="3">男 Male</td><td rowspan="3">针灸科主任 Acupuncture HOD
林元凱, 主治中医师
Mr. Lim Yuan Khay
Senior TCM Practitioner
硕士学位
广州中医药大学
MMed (TCM) GZUCM</td><td>中医脑病科
TCM Neurology Issues</td><td>中风后遗症等
Post-stroke, etc.</td></tr>
<tr><td>中医肿瘤问题
TCM Oncological Issues</td><td>肿瘤后问题等
Post-Oncological Issues, etc</td></tr>
<tr><td>中医下肢体关节疾病
Lower Limbs Disorder</td><td>腰腿下肢久病慢性疼痛、坐骨神经痛、神经损伤后疼痛、肋间神经痛等
Chronic pain in lower limbs, sciatica, post-nerve injury, intercostal neuralgia, etc.</td></tr>
<tr><td rowspan="3">女 Female</td><td rowspan="3">邹征希, 主治中医师
Ms. Chew Zheng Xi
Senior TCM Practitioner
硕士学位
天津中医药大学
MMed (TCM) TJUTCM</td><td>中医耳鼻喉科
TCM ENT Issues</td><td>头痛头胀、头晕、面瘫、面痛、耳鸣、过敏性鼻炎、鼻窦炎、急慢性咽炎、口腔溃疡等
Headache tension, migraine, dizziness, facial numbness, facial pain, tinnitus, allergic rhinitis, sinusitis, acute, and chronic pharyngitis, oral ulcer, etc.</td></tr>
<tr><td>中医眼科
TCM Ophthalmology Issues</td><td>眼睑痉挛、视疲劳、睑缘炎、视力退化、斜视、复视等眼睛问题
Blepharospasm, visual fatigue, blepharitis, vision deterioration, strabismus, double vision, etc.</td></tr>
<tr><td>中医皮肤美容科
TCM Dermatology and Cosmetology Issues</td><td>湿疹、带状疱疹、皮肤瘙痒、唇炎、汗斑、黄褐斑、痤疮、皮肤松弛等皮肤问题
Eczema, chickenpox, skin itching, cheilitis, tinea versicolor, pigmentation, acne, skin sagging, etc.</td></tr>
<tr><td rowspan="2">男 Male</td><td rowspan="2">郑裕强, 主治中医师
Mr. Chia Yi Keong
Senior TCM Practitioner
硕士学位
广州中医药大学
MMed (TCM) GZUCM</td><td>中医内科疾病
TCM Internal Issues</td><td>心悸心慌、心胸痛、睡眠障碍、焦虑抑郁、咳嗽喘气、胃胀胃痛、呕吐腹泻、尿频夜尿、肾病等。
Palpitations and panic, chest pain, sleep disorders, anxiety and depression, cough, abdominal bloating and stomach pain, vomiting and diarrhea, frequent urination and nocturia, renal issues, etc.</td></tr>
<tr><td>中医急性疼痛
TCM Acute pain</td><td>急性筋伤、软组织损伤、急性扭伤、非特异性疼痛
Acute muscle strain, soft tissue injury, acute sprain, non-specific pain.</td></tr>
<tr><td rowspan="3">女 Female</td><td rowspan="3">伍治愉, 中医师
Ms. Ng Zhi Yee
TCM Practitioner
学士学位
广州中医药大学
BMed (TCM) GZUCM</td><td>中医上肢体关节疾病
Upper Limbs Disorder</td><td>肩、颈、上肢关节疼痛、肩周炎、网球肘、上肢麻痹等
Chronic Pain in Upper Limbs, Frozen Shoulder, Tennis Elbow, Upper Limb Numbness, etc</td></tr>
<tr><td>中医妇科疾病
TCM Gynaecological Issues</td><td>月经失调、痛经、白带异常、备孕、产后调理等
Menstrual disorder, Menstrual pain, Abnormal Leucorrhea, Birth Planning, Postpartum Recovery, etc.</td></tr>
<tr><td>中医内分泌疾病
TCM NeiFenMi (Endocrinology) Issues</td><td>慢性疲劳综合症、免疫调节、代谢综合症、消化内分泌等
Chronic Fatigue Syndrome, Immune Regulation, Metabolic Syndrome, Gastrointestinal Endocrine Regulation, etc.</td></tr>
</table>

Appendix D

CONSENT FOR CARE EXTENSION TO TRADITIONAL AND COMPLEMENTARY MEDICINE (T&CM) SERVICES FORM (TO UNIVERSITI TUNKU ABDUL RAHMAN (UTAR) T&CM CENTRE)

This form must be filled out by patients who wish to obtain T&CM services. Please read the contents of this form carefully. Please refer to the healthcare personel if there is anything you would like to clarify in this form.

CERTIFICATE OF CONSENT

Patient's Name:		
Identity Card/ Passport No.:		
Patient Registration No.:		
Age:	**Gender:**	**Race:**
Address:		
Phone:	**Email:**	

Referral MOH Facility:	
Address:	
Phone:	**Email:**

I agree and give my consent to receive a care extension to the UTAR T&CM Centre for T&CM services. I acknowledge that I have been fully informed about the procedures for obtaining these services at UTAR T&CM Centre and understand the explanation provided.

I understand that I have the right to ask any questions regarding the services before signing this declaration. I confirm that this decision is made voluntarily and of my own free will. I take full responsibility for any possible consequences arising from my consent or actions. The acceptance of this care extension is based on my consent, and I reserve the right to withdraw it at any time without justification.

I understand and agree that any expenses arising from T&CM services received at the UTAR T&CM Centre including consultations, treatments, medications, equipment, and transportation—will be my sole responsibility.

I acknowledge that the procedures and potential risks of the T&CM services will be explained to me in detail by the UTAR T&CM Centre.

I agree not to take any legal action against the Government, the hospital, the clinic, the practitioner, or any other relevant party in the event of any unforeseen circumstances resulting from my decision.

Signature of patient/ guardian:

Name:
Identity Card/ Passport No.:
Date:

Signature and stamp of Registered Medical Practitioner:

Name:
MMC Registration No.:
Department:
Date:

Patient may contact UTAR T&CM Centre by telephone: 05-4620130 or email:* ***u.tcmcentre@yahoo.com.*

Appendix D

BORANG PERSETUJUAN BAGI LANJUTAN PENJAGAAN KEPADA PERKHIDMATAN PERUBATAN TRADISIONAL DAN KOMPLEMENTARI (PT&K) (KE PUSAT PT&K UNIVERSITI TUNKU ABDUL RAHMAN (UTAR))

Borang ini perlu diisi oleh pesakit yang ingin mendapatkan perkhidmatan PT&K. Sila baca kandungan borang ini dengan teliti. Sila rujuk kepada anggota kesihatan sekiranya terdapat sebarang pertanyaan.

PERAKUAN PERSETUJUAN

Nama Pesakit:		
No. Kad Pengenalan/ Pasport:		
No. Pendaftaran Pesakit:		
Umur:	**Jantina:**	**Bangsa:**
Alamat:		
Telefon:	**Emel:**	

Fasiliti KKM yang merujuk:	
Alamat:	
Telefon:	**Emel:**

Saya bersetuju untuk diberi lanjutan penjagaan di Pusat PT&K UTAR bagi menerima perkhidmatan PT&K. Saya mengakui bahawa saya telah diberikan penerangan yang lengkap mengenai prosedur untuk mendapatkan perkhidmatan ini di Pusat PT&K UTAR dan memahami penjelasan yang telah diberikan.

Saya faham bahawa saya berhak untuk bertanya sebarang soalan berkaitan perkhidmatan yang akan diberikan sebelum menandatangani deklarasi ini. Saya mengesahkan bahawa keputusan ini dibuat secara sukarela dan atas kehendak saya sendiri. Saya akan bertanggungjawab sepenuhnya terhadap sebarang kemungkinan akibat persetujuan atau tindakan saya. Penerimaan lanjutan penjagaan ini adalah tertakluk kepada persetujuan saya, dan saya berhak untuk menolaknya pada bila-bila masa tanpa sebarang justifikasi.

Saya faham dan bersetuju bahawa segala perbelanjaan yang timbul daripada perkhidmatan PT&K yang diterima di Pusat T&CM UTAR termasuk rundingan, rawatan, ubat-ubatan, peralatan dan pengangkutan adalah di bawah tanggungjawab saya sepenuhnya.

Saya faham bahawa prosedur dan risiko bagi perkhidmatan PT&K akan dijelaskan secara terperinci oleh Pusat PT&K UTAR.

Saya bersetuju untuk tidak mengambil sebarang tindakan undang-undang terhadap Kerajaan, hospital, klinik kesihatan, pengamal, atau mana-mana pihak berkaitan sekiranya berlaku sebarang perkara yang tidak diingini akibat keputusan saya ini.

Tandatangan pesakit/ penjaga:

Nama:
No. Kad Pengenalan/ Pasport:
Tarikh:

Tandatangan dan Cop Pengamal Perubatan Berdaftar:

Nama:
No. Pendaftaran MPM:
Jabatan:
Tarikh:

**Pesakit boleh menghubungi Pusat PT&K UTAR melalui telefon di talian 05-4620130 atau e-mel: u.tcmcentre@yahoo.com*

Appendix E

CARE EXTENSION TO TRADITIONAL AND COMPLEMENTARY MEDICINE (T&CM) SERVICES FORM
(TO UNIVERSITI TUNKU ABDUL RAHMAN (UTAR) T&CM CENTRE)

Patient's Name:		
Identity Card/ Passport No.:		
Patient Registration No.:		
Age:	**Gender:**	**Race:**
Address:		
Phone:	**Email:**	

Referral MOH Facility:	
Address:	
Phone:	**Email:**

Patient's Chief Complaint:

Patient's Diagnosis:

Reason for Referral:

Medical History:

Please tick (√) for the referred T&CM services, if applicable:

Traditional Chinese Medicine (TCM)
- Acupuncture ☐
- Herbal Medicine ☐
- Tuina ☐
- TCM Rehabilitation ☐

Traditional Indian Medicine (TIM)
- Ayurveda ☐

Traditional Malay Medicine (TMM)
- Malay Massage ☐
- Postnatal Care ☐

Please state and describe the presence of any condition which may affect patient's eligibility to receive T&CM services, if applicable:

Signature and Stamp of Registered Medical Practitioner:

Name:
MMC Registration Number:
Department:
Date:

Patient may contact UTAR T&CM Centre by telephone: 05-4620130 or email:* ***u.tcmcentre@yahoo.com.*

Appendix E

BORANG LANJUTAN PENJAGAAN KEPADA PERKHIDMATAN PERUBATAN TRADISIONAL DAN KOMPLEMENTARI (PT&K)
(KE PUSAT PT&K UNIVERSITI TUNKU ABDUL RAHMAN (UTAR))

Nama Pesakit:		
No. Kad Pengenalan/ Pasport:		
No. Pendaftaran Pesakit:		
Umur:	**Jantina:**	**Bangsa:**
Alamat:		
Telefon:	**Emel:**	

Fasiliti KKM yang merujuk:	
Alamat:	
Telefon:	**Emel:**

Aduan Utama Pesakit:

Diagnosis Pesakit:

Sebab Rujukan:

Sejarah Perubatan:

Sila tandakan (√) bagi perkhidmatan PT&K yang dirujuk, jika berkenaan:

Perubatan Tradisional Cina (PTC)
- Akupunktur ☐
- Perubatan Herba ☐
- Tuina ☐
- Rehabilitasi PTC ☐

Perubatan Tradisional India (PTI)
- Ayurveda ☐

Perubatan Tradisional Melayu (PTM)
- Urut Melayu ☐
- Penjagaan Postnatal ☐

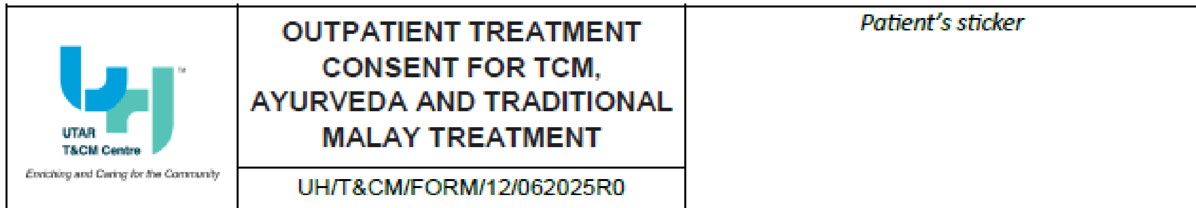
Sila nyatakan dan huraikan sebarang keadaan yang boleh menjejaskan kelayakan pesakit untuk menerima perkhidmatan PT&K, sekiranya berkaitan:

Tandatangan dan Cop Pengamal Perubatan Berdaftar:

Nama:
No. Pendaftaran MPM:
Jabatan:
Tarikh:

**Pesakit boleh menghubungi Pusat PT&K UTAR melalui telefon di talian 05-4620130 atau e-mel: u.tcmcentre@yahoo.com*

Appendix F1



UTAR T&CM Centre *Enriching and Caring for the Community*	OUTPATIENT TREATMENT CONSENT FOR TCM, AYURVEDA AND TRADITIONAL MALAY TREATMENT	*Patient's sticker*
	UH/T&CM/FORM/12/062025R0	

I, ...

IC No./Passport No.: .... acknowledged that:

- ☐ I am informed that the T&CM treatment may not give the expected result even though the treatment is carried out with due care and skill, and that there are no guarantees for the result of treatment, T&CM does not often provide an instant cure. The length of my treatment depends on the severity of my condition, and my symptoms may temporarily worsen before they begin to improve to some extent.

- ☐ I am aware of the risks and side-effects of T&CM treatments, which can include, but are not limited to: slight pain, light-headedness, light-dizziness or nausea, soreness, bruising, bleeding or discoloration of the skin, and the possibility of other unpredictable risks. I freely accept the risks related to my treatment.

- ☐ I consent to T&CM therapies by my Registered T&CM Practitioner. I understand that there are no guarantees regarding the cure or improvement of my condition.

- ☐ I understand that the herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese, Indian and Malay Medicine.

- ☐ I understand that T&CM treatments may be inappropriate during pregnancy if it is applicable to me. Accordingly, I agree to alert my practitioner if I am or become pregnant and understand that this is a continuing obligation.

- ☐ If I experience any gastrointestinal symptoms or allergic reactions to the herbs, I shall stop taking the herbs and immediately inform the T&CM practitioner in charge.

- ☐ I understand that my Registered T&CM Practitioner may review my medical records and laboratory reports, but all my records will be kept strictly private and confidential and will not be released without my consent.

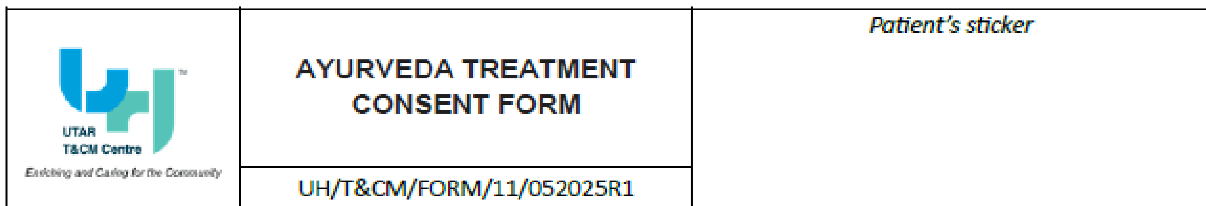
- ☐ I also understand and agree that it may be necessary for my T&CM practitioner to hold discussions with other healthcare professionals regarding my treatment plan.

- ☐ I understand that I have been given the opportunity to ask any questions regarding my treatment before signing this form. I have the right to refuse or discontinue any treatment at any time by writing and I hereby release the practitioner(s) and the T&CM Centre from any liability arising from my decision to refuse or discontinue treatment.

Additional information:

	Signature / Thumb Print *Left/Right	**Name**	**NRIC / Passport No.**	**Date & Time**
Attending Practitioner		APC No: ____________		
Patient / Parent / Guardian / Next of Kin / Legal Representative / Other: ____________				
Witness				
Translator (where applicable)				

Appendix F2



UTAR T&CM Centre — Enriching and Caring for the Community	AYURVEDA TREATMENT CONSENT FORM	*Patient's sticker*
	UH/T&CM/FORM/11/052025R1	

I, ... NIRC / Passport No ....
(Name of patient or patient's legal representative)

Here by giving permission of ayurveda treatment to be conducted to:

.... NIRC / Passport No ....
(Name of patient)

acknowledge that: .... has:
(Name of T&CM Practitioner)

1. Explained to me the nature, consequences and risk of the proposed Traditional and Complementary Medicine (T&CM) treatment.
2. Informed me of the likely consequences of me/ the patient not undertaking the treatment.
3. Provided the opportunity to ask questions about the T&CM treatment, and I am satisfied with the explanation and the answers given by the T&CM Practitioner.
4. Outline any alternative treatment or courses of action that may be reasonably considered.
5. Explained that the T&CM treatment may not yield the expected result even when carried out with due care and skill.
6. Described the nature, purpose, and likely results of the following T&CM treatment:

Treatment Options: Ayurveda Detox Programme / Herbal Medicine / Oil Massage / ____________________

Diagnosis:____

Please check to acknowledge each of the following statements:

[ ] I understand that the treatment plan includes detoxification, fasting, and controlled purging procedures.

[ ] I also understand that continuing certain long-term medications prescribed to me/ the patient and taking them as directed may interfere with the treatment plan. I hereby provide my consent for the temporary withdrawal or alteration of the dosage of the medications mentioned above for me / the patient during the treatment plan.

[ ] I acknowledge that I/ the patient has not been dissuaded by the T&CM practitioner(s) from taking such prescribed medication. I also acknowledge that this decision may lead to potential complications and consequences, including but not limited to: Hypoglycaemia/Hypotension due to detoxification, fasting, and purging procedures. Interference with the efficacy of the treatment plan

[ ] I will inform my/ the patient practitioner if I/ the patient currently has or develop any major health issues, if I/ the patient suffers from any type of major bleeding disorder, or if I/ the patient use a pacemaker, or if I/ the patient am carrying any infectious agents, including but at not limited to HIV, TB and Hepatitis.

*Page **1** of **2***

[ ] I understand that there are no guarantees for the results of treatments. T&CM does not often provide an instant cure. The length of my/ the patient treatment depends on the severity of my/ the patient condition. In some cases, my/ the patient symptoms may temporarily worsen before they begin to improve.

[ ] I have discussed the content of this form with my/ the patient practitioner. I acknowledge that I have asked any questions I may have and received answers I understand. I voluntarily consent for me/ the patient to receive T&CM Treatment and understand that I may withdraw my consent and halt my/ the patient participation at any time.

[ ] I hereby take full responsibility for this decision and shall release the T&CM practitioner(s) and UTAR T&CM Centre as well UTAR Hospital from any consequences arising from this decision.

[ ] I also acknowledge that in case of a medical emergency, I/ the patient may be shifted, at my cost, to a nearby hospital where diagnosis and treatment will be rendered as per conventional protocol. I also hereby take full responsibility for this and shall release the T&CM practitioner(s) and UTAR T&CM Centre as well UTAR Hospital from any claims of any nature that result from my failure to pursue medical remedies for any physical ailments I/ the patient may have.

	Signature / Thumb Print *Left/Right	**Name**	**NRIC / Passport No.**	**Date / Time**
Attending Practitioner				
Patient / Parent / Guardian / Next of Kin				
Witness				
Translator (where applicable)				

Appendix F3

UTAR T&CM Centre Enriching and Caring for the Community	**TRADITIONAL CHINESE MEDICINE TREATMENT CONSENT FORM**	*Patient's sticker*
	UH/T&CM/FORM/12/062025R2	

I, the undersigned .... NIRC / Passport No ....

hereby authorised and consent to the Traditional Chinese Medicine treatment to be conducted on:

.... NIRC / Passport No ....
(Name of patient)

I acknowledge that: .... has:
(Name of T&CM Practitioner)

1. Explained to me the nature, consequences and risk of the proposed Traditional and Complementary Medicine (T&CM) treatment.
2. Informed me of the likely consequences of me/ the patient not undertaking the treatment.
3. Provided the opportunity to ask questions about the T&CM treatment, and I am satisfied with the explanation and the answers given by the T&CM Practitioner.
4. Outlined any alternative treatment or courses of action that may be reasonably considered.
5. Explained that the T&CM treatment may not yield the expected result even when carried out with due care and skill.
6. Described the nature, purpose, and likely results of the following T&CM treatment:

Treatment Options: Chinese Herbal Treatment / Acupuncture / Moxibustion / Cupping / Gua Sha / Tuina / __________

Diagnosis: ____

Please check to acknowledge each of the following statements:

[ ] I understand that the herbs recommended, which are derived from plant, animal, and mineral sources, are traditionally considered safe in the practice of Chinese Medicine. If I/the patient experience any gastrointestinal symptoms or allergic reactions, I/the patient will stop taking the herbs and immediately inform the T&CM practitioner in-charge.

[ ] I understand that some of the techniques used under the scope of T&CM include acupuncture, acupressure, the electrical stimulation of needles, cupping or moxibustion, and Tuina. Before any of these treatments are performed, my/the patient's practitioner will discuss my/ the patient treatment options and only proceed if my/ patient's consent is given.

[ ] I acknowledge that I have been informed and made aware that the treatment may involve certain risks and side effects, including but are not limited to: slight pain, light- headedness or nausea, soreness, bruising, bleeding or discoloration of the skin, and the possibility of other unforeseen risks. I freely accept the risks involved with my/the patient treatment.

*Page **1** of **2***

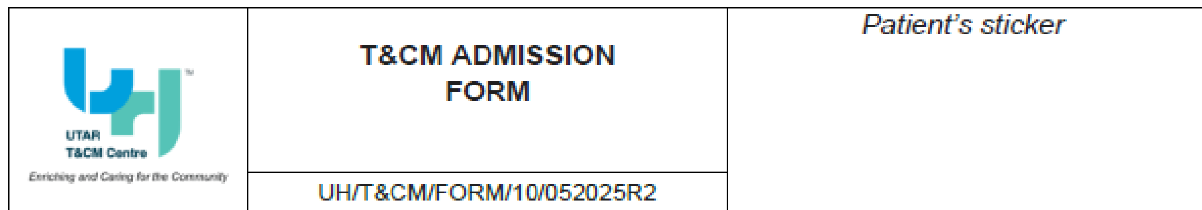
[ ] I undertake to inform my/the patient's practitioner if I/ the patient currently have or develop any major health issues, if I / the patient suffer from any type of major bleeding disorder, or if I / the patient use a pacemaker, or if I / the patient am carrying any infectious agents, including but at not limited to HIV, TB and Hepatitis.

[ ] I understand that results from Traditional and Complementary Medicine (T&CM) treatments are not guaranteed, and outcomes may vary between individuals. T&CM treatments often do not provide immediate or complete relief. The duration, frequency, and number of sessions required will depend on the nature, complexity, and severity of my / the patient's condition. I acknowledge that in some cases, symptoms may temporarily worsen or fluctuate before any improvement is observed.

[ ] I confirm that I have discussed the content of this consent form with my/the patient's practitioner. I acknowledge that I have asked any questions I may have and received answers accordingly. I voluntarily consent for me/ the patient to receive T&CM Treatment. I understand that I/the patient may withdraw this consent and discontinue treatment at any time by providing written notice to my/the patient's practitioner. I acknowledge that withdrawing consent may affect the course and effectiveness of the treatment, and I hereby release the practitioner(s) and the T&CM Centre from any liability arising from my/the patient's decision to discontinue treatment.

	Signature / Thumb Print *Left/Right	**Name**	**NRIC / Passport No.**	**Date / Time**
Attending Practitioner				
Patient / Parent / Guardian / Next of Kin / Legal Representative / Other: ______________				
Witness				
Translator (where applicable)				

Appendix G



UTAR T&CM Centre *Enriching and Caring for the Community*	**T&CM ADMISSION FORM** UH/T&CM/FORM/10/052025R2	*Patient's sticker*

AdmittingPractitioner: .... Admission Date & Time ....

ADMISSION CRITERIA & GUIDE

ALLOW TO BE ADMIT	NOT ALLOW TO BE ADMIT
■ Stable post-stroke rehabilitation, hemiplegia, and other neurologically related disorders. ■ Acute arthralgia, post-fracture rehabilitation, soft tissue injury. ■ Person who are conscious and could live independently (move, eat, bath). ■ Needless of nasogastric tube, urinary catheter or other medical aids. ■ Patients are able to cope with general diets and allergic diets (special diets are not provided).	■ All types of diseases other than the above criteria (infectious diseases, malignant tumors, underlying cardiovascular and cerebrovascular diseases, advanced chronic diseases, paralysis, permanent disability, severe mental illness, open trauma, major postoperative surgery, etc). ■ Every Practitioner has the right to assess whether the disease is at risk of worsening and decide whether to admit patients or not.

ON DAY OF ADMISSION
- Check in at the UTAR T&CM Centre at the time advised by your practitioner.
- Bring along the medications in the original packaging.
- Wear comfortable clothing and non-slip footwear.

PERSONAL ITEMS
- Patients may like to bring personal items such as pajamas and toiletries.
- Do not keep large sums of money, jewelry and other valuables during your stay. UTAR T&CM Centre will not be responsible for the loss of any items.

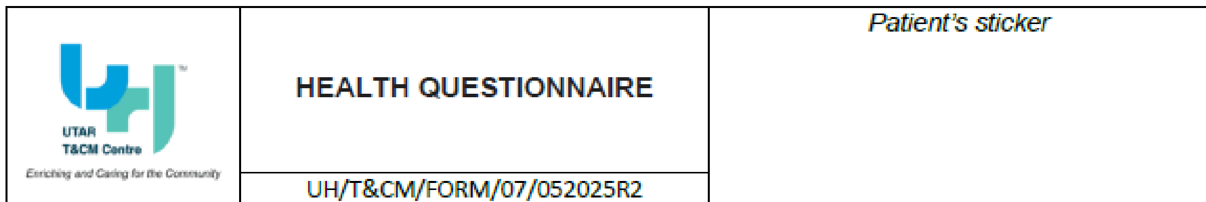
TIME IN HOSPITAL
- You will be required to stay in until you are clinically fit for discharge with a maximum of 3 months.
- Please look for the nurses if you have any special needs.
- Patients and their visitors should be courteous, considerate and respectful towards others.
- If there is an emergency, we will send you to Emergency Department, UTAR Medical Centre.

DISCHARGE INFORMATION
- UTAR T&CM Centre provides comprehensive information both before and after your treatment to assist patients to be fully informed, prepared and in control of your planning for discharge.
- Before you leave, an outpatient appointment may be made for post discharge follow-up treatment.
- All patients are given the opportunity to provide feedback, formally and informally.
- In the event of medical emergency, the practitioner in charge has the authority to decide for transfer of care.

TAKING CARE AT HOME
- You must have a responsible adult drive you home and may stay with you overnight.
- Follow the instructions given by the practitioner.

PRIVACY INFORMATION
- The privacy of your personal information is important to us and we are committed to ensuring it is protected.
- UTAR T&CM Centre complies with the Malaysia Privacy Principles in relation to the management of personal information.
- The intended recipients of your health information are staff involved in your care, data service providers engaged from time to time, other governmental departments or legal entities, where disclosure is obliged by law.
- You have the right to request access to, and request correction of, your health information in accordance with the relevant legislation.

Appendix H



HEALTH QUESTIONNAIRE

UH/T&CM/FORM/07/052025R2

Patient's sticker

PLEASE ENSURE ALL QUESTIONS ARE COMPLETED

No	Content	Yes	No	Remarks
	ALLERGIES (QUESTION 1 - 3)			
1	Have you ever had a reaction to DRUGS: ____________________________________			
2	Have you ever had a reaction to FOOD: ____________________________________			
3	Have you ever had a reaction to OTHER: ___________________________________			
	CARDIAC (QUESTION 4 - 12)			
4	Have you ever had a heart attack If YES, Year: ________________			
5	Have you ever had heart surgery If YES, Year: ________________			
6	Do you have a pacemaker/internal defibrillator Make: Model: Last checked:			
7	Do you have cardiac stents Type: ▫ Bare Metal ▫ Drug Eluting Date implanted:			
8	Do you have any other heart problem			
9	Do you have palpitations			
10	Do you have an irregular heartbeat			
11	Do you have a tendency to bleed, clot or bruise easily			
12	Have you ever had high blood pressure			
	RESPIRATORY (QUESTION 13 - 17)			
13	Do you smoke If YES, Daily amount: Date ceased:			
14	Do you have Asthma			
15	Do you have Bronchitis			
16	Do you have Sleep apnea			

17	Do you use a nebulizer, puffer or EPAP/CPAP machine or home Oxygen (please bring puffers with you)			
DIABETES (QUESTION 18 - 19)				
18	Do you have diabetes If yes: ◻ Type I ◻ Type Ⅱ ◻ Unsure Controlled by: ◻ Diet ◻ Tablet ◻ Insulin			
19	If you take insulin has your Doctor given you instructions regarding your Diabetic Medication ◻ Yes ◻ No If no, please contact them for advice.			
GASTROINTESTINAL (QUESTION 20 - 22)				
20	Have you ever suffered from reflux or heartburn			
21	Do you have hiatus hernia/gastrointestinal ulcers			
22	Do you have a gastric band in place			
SKELETAL/ MOBILITY (QUESTION 23 - 24)				
23	Do you have arthritis			
24	Have you experienced fainting, dizziness or fallen in the last 12 months			
OTHERS (QUESTION 25 - 36)				
25	Have you ever tested positive to Hepatitis A, B or C, HIV, TUBERCULOSIS, ESBL, MRSA, VRE or CRE?			
26	Do you have an intellectual disability			
27	Do you have Alzheimer's/Dementia			
28	Female patients, could you be pregnant If YES, Number of weeks:			
29	Do you drink alcohol If YES, Daily amount:			
30	Have you ever had a stroke If YES, Date: Residual problems:			
31	Do you suffer from migraines			
32	Have you had a recent cold, flu or unexplained temperature			
33	Do you have or have you been exposed to an infectious disease in the past 14 days? (e.g. Chickenpox, Measles)			
34	Do you have any other medical or surgical problems (e.g. Epilepsy, Liver, Kidney, Psychiatric)			
35	Have you ever been diagnosed with cancer If YES, Type of cancer: Year diagnosed:			
36	Do you currently have any skin wounds, pressure sores or skin ulcers			
MEDICATION (QUESTION 37)				
37	Do you take any medication If YES, name of medication:			

FOR PATIENT:

☐ I have read and understood the information for my visit on these pages. The answers I have given to all questions are true to the best of my knowledge and I have not withheld any information, I agree and consent to UTAR T&CM Centre collecting and using personal information about me for these purposes.

Signature:

Date: _____/_________/__________

If you require assistance or have any questions regarding the admission procedures, completion of forms, costs or health insurance status, our staff will be happy to assist you.

Page 3 of 3

Appendix I

UTAR
UNIVERSITI TUNKU ABDUL RAHMAN

TRADITIONAL & COMPLEMENTARY MEDICINE (T&CM) CENTRE

Wholly owned by UTAR Education Foundation (Co. No. 200201010564[578227-M])

Patients' Own Medicines (POM) Form

To: UTAR T&CM Centre

I am advised by non UTAR T&CM Centre/UTAR Hospital practitioners to undergo the following medicines for my health condition:

No	Medication/Vitamin/ Other Supplements	Dose	Frequency	Comments

I am using POM at my own risk and T&CM Centre's Nurses or PCAs or others remind and assist me to take the above-mentioned POM.

Signature: ____________________ Date and Time: ____________________
Patient/next of kin

Appendix J

EVALUATION REPORT OF PATIENTS NOT SUITABLE TO RECEIVE TRADITIONAL AND COMPLEMENTARY MEDICINE (T&CM) SERVICES (AT UNIVERSITI TUNKU ABDUL RAHMAN (UTAR) T&CM CENTRE)

Patient's Name:		
Identity Card/ Passport No.:		
Age:	Gender:	Race:
Address:		
Phone:	Email:	

Referral MOH Facility:	
Referral Registered Medical Practitioner:	
Referral Date:	
Address:	
Phone:	Email:

1) **Reason for referral:**

2) **Patient's Diagnosis (based on referral):**

3) **T&CM Diagnosis:**
   - **Disorder:**
   - **Pattern:**

4) **Proposed T&CM services:**

5) **Reason patients not suitable to receive T&CM services:**

6) **Arising health concerns, if any:**

7) **Further plan for patient, if applicable:**

Signature and Stamp of T&CM Practitioner:

Name:
Registration No.:
Date:

Appendix J

LAPORAN PENILAIAN PESAKIT YANG TIDAK SESUAI MENERIMA PERKHIDMATAN PERUBATAN TRADISIONAL DAN KOMPLEMENTARI (PT&K) (DI PUSAT PT&K UNIVERSITI TUNKU ABDUL RAHMAN (UTAR))

Nama Pesakit:		
No. Kad Pengenalan/ Pasport:		
Umur:	Jantina:	Bangsa:
Alamat:		
Telefon:	Emel:	

Fasiliti KKM yang merujuk:	
Pengamal Perubatan Berdaftar yang merujuk:	
Tarikh rujukan:	
Alamat:	
Telefon:	Emel:

1) **Sebab rujukan pesakit:**

2) **Diagnosis Pesakit (berdasarkan rujukan):**

3) **Diagnosis PT&K**
   - *Disorder:*
   - *Pattern:*

4) **Perkhidmatan PT&K yang dicadangkan:**

5) **Sebab pesakit tidak sesuai menerima perkhidmatan PT&K:**

6) **Isu kesihatan yang berbangkit, jika ada:**

7) **Perancangan lanjut bagi pesakit, sekiranya berkaitan:**

Tandatangan dan Cop Pengamal PT&K:

Nama:
No. Pendaftaran:
Tarikh:

Appendix K

EVALUATION REPORT OF PATIENTS RECEIVING TRADITIONAL AND COMPLEMENTARY MEDICINE (T&CM) SERVICES (AT UNIVERSITI TUNKU ABDUL RAHMAN (UTAR) T&CM CENTRE)

Patient's Name:		
Identity Card/ Passport No.:		
Age:	**Gender:**	**Race:**
Address:		
Phone:	**Email:**	

Referral MOH Facility:	
Referral Registered Medical Practitioner:	
Referral Date:	
Address:	
Phone:	**Email:**

1) Reason for referral:

2) Patient's Diagnosis (based on referral):

3) T&CM Diagnosis:
- **Disorder:**
- **Pattern:**

4) Summary of T&CM services provided:

Please tick (√) which is applicable.

Traditional Chinese Medicine (TCM)
- Acupuncture [ ]
- Herbal Medicine [ ]
- Tuina [ ]
- TCM Rehabilitation [ ]

Traditional Indian Medicine (TIM)
- Ayurveda [ ]

Traditional Malay Medicine (TMM)
- Malay Massage [ ]
- Postnatal Care [ ]

Prescribed T&CM treatment regime:

[ ] Outpatient
Date for 1st session:
Date for last session:

[ ] Inpatient
Admission date:
Discharge date:
Total length of stay (days):

Total number of sessions:

Completed treatment regime? [ ] Yes [ ] No
If no, please state the reason:

Additional information:
Please attach relevant documents (e.g., type of herbal medicine used etc.)

5) Disease progress and T&CM treatment outcomes:
Please provide relevant information on the patient's disease progress and T&CM treatment outcomes.

Assessment

Parameter*	Pre-treatment (Baseline)	Mid-treatment	Post treatment

*e.g.: pain score, Modified Barthel Index (MBI) score, etc.
Please specify the date and number of sessions received during assessment.

6) Arising health concerns (including clinical adverse event), if any:

7) Discharge summary and Recommendation:

Signature and Stamp of T&CM Practitioner:

Name:
Registration No.:
Date:

Appendix K

LAPORAN PENILAIAN PESAKIT YANG MENERIMA PERKHIDMATAN PERUBATAN TRADISIONAL DAN KOMPLEMENTARI (PT&K) (DI PUSAT PT&K UNIVERSITI TUNKU ABDUL RAHMAN (UTAR))

Nama Pesakit:		
No. Kad Pengenalan/ Pasport:		
Umur:	**Jantina:**	**Bangsa:**
Alamat:		
Telefon:	**Emel:**	

Fasiliti KKM yang merujuk:	
Pengamal Perubatan Berdaftar yang merujuk:	
Tarikh rujukan:	
Alamat:	
Telefon:	**Emel:**

1) Sebab rujukan pesakit:

2) Diagnosis Pesakit (berdasarkan rujukan):

3) Diagnosis PT&K

- ***Disorder:***
- ***Pattern:***

4) Rumusan Perkhidmatan PT&K yang diberikan:

Sila tandakan (√) mana yang berkenaan.

Perubatan Tradisional Cina (PTC)

- Akupunktur [ ]
- Perubatan Herba [ ]
- Tuina [ ]
- Rehabilitasi PTC [ ]

Rejim rawatan PT&K yang ditetapkan:

Perubatan Tradisional India (PTI)

- Ayurveda [ ]

Perubatan Tradisional Melayu (PTM)

- Urut Melayu [ ]
- Penjagaan Postnatal [ ]

[ ] Pesakit Luar
Tarikh untuk sesi pertama:
Tarikh untuk sesi terakhir:

[ ] Pesakit Dalam
Tarikh kemasukan wad:
Tarikh discaj:
Jumlah tempoh tinggal (hari):

Jumlah sesi rawatan:

Selesai rejim rawatan PT&K? [ ] Ya [ ] Tidak
Jika tidak, sila nyatakan sebab:

Maklumat tambahan:
Sila lampirkan dokumen yang berkenaan (contoh: jenis ubat herba yang digunakan dsb.)

5) Perkembangan penyakit dan hasil rawatan PT&K:
Sila berikan maklumat berkaitan perkembangan penyakit pesakit serta hasil rawatan PT&K.

Penilaian

Parameter*	Sebelum rawatan (*Baseline*)	Pertengahan rawatan	Selepas rawatan

*contoh: skor kesakitan, skor *Modified Barthel Index* (MBI) dsb.
Sila nyatakan tarikh dan bilangan sesi yang diterima semasa penilaian.

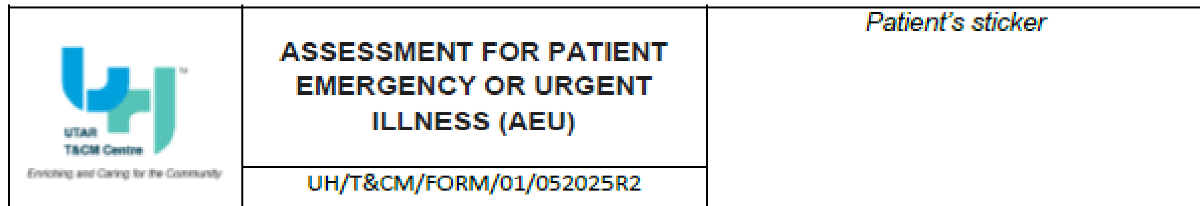
6) Isu kesihatan yang berbangkit (termasuk kejadian advers klinikal), jika ada:

7) Rumusan discaj dan Cadangan:

Tandatangan dan Cop Pengamal PT&K:

Nama:
No. Pendaftaran:
Tarikh:

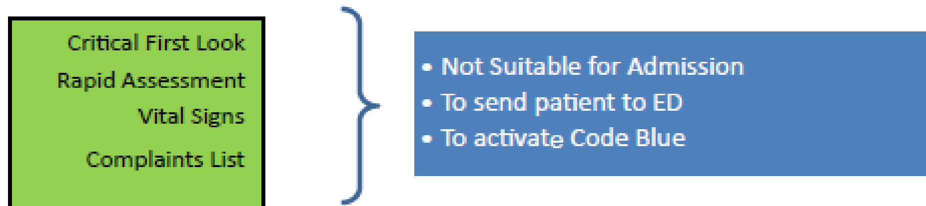
Appendix L



UTAR T&CM Centre	ASSESSMENT FOR PATIENT EMERGENCY OR URGENT ILLNESS (AEU)	*Patient's sticker*
	UH/T&CM/FORM/01/052025R2	

OVERVIEW OF RISK ASSESSMENT IN UTAR T&CM OPD AND WARD.

OVERALL RISK ASSESSMENT IN ADULTS:



OVERVIEW STATEMENTS

- The AEU is the first point of contact for all patients accessing the services of the UTAR T&CM Centre OPD and Ward. This assessment is designed to sort out patients according to their degree of severity, ensuring the safety of the patients while ensuring that they are managed appropriately and are provided with appropriate resources for treatment.

- The AEU is designed to be conducted for the patient in OPD, before the patient is admitted to the ward or during the stay in ward, which will determine priority, resources, etc. This is vital to facilitate patient and nursing care flow and treatment flow through the UTAR T&CM Centre.

- Categorization of the AEU is based on the severity of the patient's condition, and urgency of treatment needs, which is determined by critical first look, rapid assessment, vital signs, complaints list, urgency of treatment needs, general examination from head to toe and certain specific examinations (if found abnormal).

- The AEU should be repeated if new symptoms develop, symptoms worsen or the patient's condition appears to change in OPD or ward.
- This AEU is referred and developed from "Malaysian Triage Scale for Emergency and Trauma Departments (version 2019)".

Checklist for Patient's Emergency and Urgent Illness (AEU)

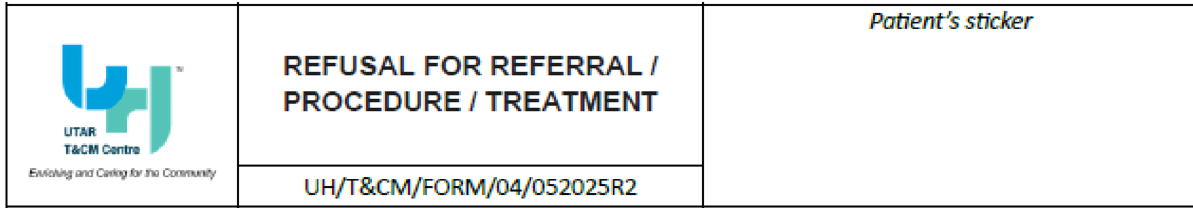
- Please activate "**Code Blue**" immediately if patient with **asphyxiated or cardiac arrest needing CPR** (cardiopulmonary resuscitation).
- Please send patient to Emergency Department for further management if patient fails in this Checklist.

No	Content	Yes	No
1	Appearance: Not responding to call; Acute Severe Chest Pain; Ongoing Seizures; Severe Respiratory Distress.		
2	Respiratory Distress: **Acute Confusion**; Breathless, lethargic require assisted breathing; or wheezing or rhonchi or high respiratory rate with **SpO2 ≤ 94%** (when patient usual baseline ≥ 95%) on room air.		
3	Hyperacute Stroke (**0 – 24 hours**); Acute Stroke (**>1 day to 7 days**). (Based on International Stroke Recovery & Rehabilitation Roundtable.)		
4	Shock State (Peripheries, Pulses, AVPU): Significant **Tachycardia: > 120/min**; significant **Bradycardia: < 50/min**; Acute Confusion; **CRT > 2 seconds**.		
5	Aggressive Persons, Potentially Violent, Violent Persons/Weapons.		
6	Altered Mental State: Associated Seizures; Neuro Deficits; Agitated; Confused; **Capillary Blood Glucose < 4 mmol/L** (considered hypoglycemia needing IV dextrose in ED).		
7	Palpitation: With associated vital sign abnormalities; Ongoing chest pain, breathlessness, altered mental state; Associated syncope, chest pain.		
8	Vital Signs (Adult): **SBP < 90 mmHg or Mean Arterial Pressure [MAP=(SBP+2DBP)/3] < 65 mmHg**; **HR > 120/min**; **RR > 30/min**; **BP > 220/120 mmHg** with symptoms or No symptoms; **BP > 180/110 mmHg** with mild symptoms; **SpO2 ≤ 94%** (when patient usual baseline ≥ 95%) on room air; **Temp > 39** C or **< 36** C; Appears Septic; Acutely when **GCS < 15** (when baseline GCS=15).		
9	Shortness of Breath: Stridor; Altered conscious level; Ongoing chest pain; Rapid breaths; Wheeze, expiratory rhonchi.		
10	Chest Pain: New Onset; Occurs with sweating or vomiting or radiation to jaw or shoulder; Or occurs on exertion; Arrhythmias on ECG.		
11	ECG (12 Lead ECG): Any ST Elevation or depression, heart AV block, arrhythmias; Untreated Atrial Fibrillation; Frequent ectopic; Sinus Pauses; Tall Tented T Waves.		
12	**Glucose < 4 mmol/L** with symptoms. Hyperglycemia with acidosis.		
13	Headache: Altered mental state; **Pain Score >** 7; Sudden onset or thunderclap (maximum intensity within ≤ one minute); Visual / Speech difficulty; Ataxia / Gait difficulty; Vomiting.		
14	Dizziness / Giddiness / Vertigo: Altered Conscious level; Neurological Deficit; Visual / Speech difficulty; Ataxia / Gait difficulty.		

No	Content	Yes	No
15	Diarrhea/Vomiting: Fresh blood PR; Fresh blood hematemesis; Altered consciousness; Bloody diarrhea; Black stools; Coffee ground vomitus; Anticoagulant use; Persisting vomiting; Unable to tolerate orally.		
16	Dehydration: Fainting; Severe muscle contractions; Convulsions; Sunken dry eyes; Lack of firmness and elasticity of the skin; Rapid and deep breathing; Fast and weak pulse; **Tachycardia > 120/min.**		
17	Abdominal Pain: Bleeding PR (per rectum) / PO (per oral); Tense Rigid Abdomen; **Pain Score >** 7; Very sudden onset; Associated Back Pain; Possibly Pregnant.		
18	Low Back Pain: Associated Abdominal Pain; Neuro Deficits; Acute Loss of Urinary / Bowel Control.		
19	Gynaecology: Any Vaginal Bleeding with **pain score >** 7; Known Gynaecology Pathology with worsening symptoms.		
20	Bleeding (Seen External, Suspect Internal, Bleeding Disorders, Anti-coagulant therapy): Active uncontrolled bleeding; Massive Vaginal Bleeding; Active Vomit / Cough Blood; Suspected intra-abdominal bleeding / Ectopic / Abdominal Aortic Aneurysm (AAA); Menorrhagia; Expanding hematoma; Abdominal pain post motor-vehicle accident.		
21	Generalized Seizures: Ongoing seizures and lasts more than five minutes; High fever; Continuous seizures even though patient had been taking anti-seizure medicine; Neck stiffness; Neuro deficits; Na / Glucose abnormalities.		
22	Ear / ENT / Eye / Vision: Possible airway obstruction; Active Nose Bleeding; Difficulty Swallowing; Tracheostomy; Foreign Body ENT. Sudden Vision Loss; Painful Red-eye; Foreign Body Eye; Associate Severe Headache.		
23	Allergy / Anaphylaxis: Face / Tongue Edema; Unable to swallow; Speaking difficulty; Near-fainting; Abdominal pain; Chemical / Toxin.		
24	Scrotal Pain / Penile Trauma: Severe Pain (**pain score >** 7); Sudden onset; Persistent Vomiting. (missing testicular torsion is ground for legal action)		
25	Infectious Diseases / Poisoning / HAZMAT: Dengue; Malaria; Active tuberculosis or leptospirosis infection (Notifiable & state mortality level if anything happens); Meningoencephalitis; Melioidosis; Sexually transmitted diseases; Toxoplasmosis; Cholera; MERS Co-V / Pandemic Influenza and other emerging viruses; Meningococcemia; CRE, MRSA, and other multidrug-resistant infections; EBOLA and other re-emerging viruses; any notifiable infectious diseases as stipulated by KKM; Organophosphates and similar compounds; Chemical exposure to Eyes, ENT; HAZMAT- chemical, dry or liquid; HAZMAT-inhaled; HAZMAT- radioactive.		
26	Severe conditions or critical illnesses. Eg: terminal stage cancer with anorexia/cachexia syndrome; Acute limb ischemia; Acute pediatric illness.		
27	Need for surgical intervention, IV medications, or frequent medical procedures. (eg: Bleeding, hypo/hyperkalemia).		
28	Drug addiction as stipulated by MOH.		

Page 3 of 3

Appendix M



I, ____________________________, NIRC / Passport No. ______________________________
(patient/legal representative of the patient)

refuse for *myself/the patient ____________________, NRIC / Passport No: ____________________
to be referred for further treatment/management.

I have been given detailed explanations regarding my / the patient condition and the appropriate treatment. I understand the possible risk if the treatment is not performed. The decision was made on my own free will. I shall be fully responsible for any possible consequences arising from this action.

I affirm that I will not take any legal action against UTAR T&CM Centre / Hospital UTAR or any other relevant parties should there be any unfortunate outcome resulting from this decision.

Persetujuan Akuan Penolakan Rujukan / Prosedur / Rawatan

Dengan ini, saya, ______________________________ IC / Pasport No: ____________________
(pesakit sendiri/waris sah di sisi undang-undang)
kepada pesakit yang bernama ______________________ IC / Pasport No: __________________
tidak bersetuju untuk dirujuk bagi mendapat rujukan / prosedur / rawatan lanjut.

Saya telah dimaklum dengan jelas tentang keadaan kesihatan saya / pesakit serta rawatan yang dicadangkan. Saya faham dan sedia maklum akan risiko dan kemungkinan yang akan berlaku sekiranya rawatan tersebut tidak dijalankan. Keputusan ini dibuat atas kerelaan saya sendiri. Saya akan bertanggungjawab sepenuhnya atas akibat keputusan ini.

Saya mengesahkan bahawa saya tidak akan mengambil tindakan undang-undang terhadap UTAR T&CM Centre / UTAR Hospital atau pihak berkenaan sekiranya kejadian yang tidak diingini berlaku berikutan keputusan saya.

拒绝转诊/手术/治疗

本人：______________________________，身份证号码 ________________________，
*患者/法定代表人____，
身份证号 ____，
拒绝将*本人/患者转介至 ______________________________________。

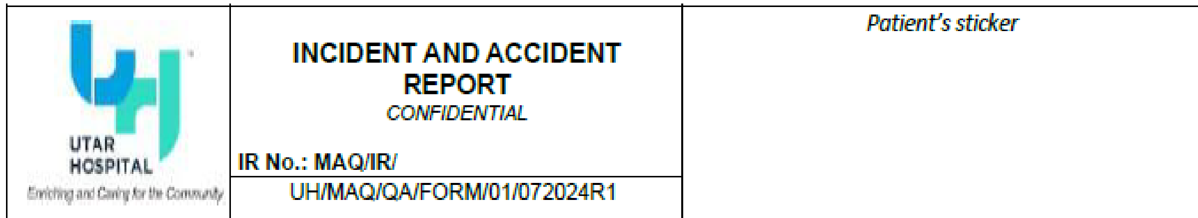
本人已被告知并了解本人/患者的病情和适当的治疗方案。本人明白若不及时进行检查或者治疗可能带来的风险。本人自愿作出以下决定。本人明白本人需要对此决定所产生的一切后果以及影响负责。
本人确认如果这一决定导致任何不幸的结果，本人不会对 UTAR T&CM 中心/ UTAR 医院或任何其他相关方采取法律行动。

Page 1 of 2

	Signature / Thumb Print *Left/Right	**Name**	**NRIC / Passport No.**	**Date / Time**
Attending Practitioner				
Patient / Parent / Guardian / Next of Kin				
Witness				
Translator (where applicable)				

*Page **2** of **2***

Appendix N



UTAR HOSPITAL *Enriching and Caring for the Community*	**INCIDENT AND ACCIDENT REPORT** *CONFIDENTIAL* **IR No.: MAQ/IR/** UH/MAQ/QA/FORM/01/072024R1	*Patient's sticker*

Note: *A Hospital incident is any happening which is not consistent with the routine operation of the Hospital and is reported by the staff. The Hospital Incident Report is generated immediately or before the end of a shift and forwarded to the Unit Head / Ward Supervisor.*

SECTION A: To be completed by staff who observed/detected/was informed of the incident.

Name of Staff: ______________________ **Department:** ______________ **Designation:** ______________

Date of Incident: ____________ **Time of incident:** ____________ **Diagnosis of Patient:** ______________________

GENERAL *(Tick the appropriate box)*

Classification of incident: ☐ Major ☐ Minor ☐ Near Miss ☐ Actual

Category: ☐ Clinical: ____________ ☐ Non - clinical: ______________________

Incident site: ☐ Western Medicine ☐ Traditional & Complementary Medicine Centre

- ☐ Chinese Medicine: Acupuncture / Internal Medicine / Tuina
- ☐ Indian Medicine: Ayurveda
- ☐ Malay Medicine

Type of Incident

- ☐ Patient-related
- ☐ Staff related
- ☐ Non-patient related e.g. visitor
- ☐ Medical Staff / Doctor
- ☐ T&CM / Chinese Practitioner related
- ☐ Security-related
- ☐ Others(specify): ______________________

Incident location

- ☐ Ward (specify): ______________________
- ☐ In the bathroom
- ☐ Clinics (specify) ______________________
- ☐ Hospital ground (specify): ______________________
- ☐ Operation Room
- ☐ Others (specify): ______________________

CLINICAL INCIDENTS *(Ticks can be more than one)*

All Areas Related Incident

1. ☐ Medication Error
2. ☐ Prescription Error / Dispensing Error
3. ☐ Adverse Drug / Blood Reaction
4. ☐ Identification Error (specify): ______________________
5. ☐ Adverse Outcome of Procedure
6. ☐ Discharge Against Medical Advice (AOR Discharge)
7. ☐ Fall / Accident
9. ☐ Radiology / Laboratory Error
9. ☐ Needle Stick Injury
10. ☐ Pressure Ulcers
11. ☐ Transfusion Error
12. ☐ Critical value notified more than 30 minutes

Anesthetic Related Incident

34 ☐ Laryngospasm / Bronchospasm
35. ☐ Failed Intubation
36. ☐ Aspiration of Gastric Content
37. ☐ Myocardial Ischemia
38. ☐ Injury to Teeth
39. ☐ Improper Anaesthetic Consent / No Consent

Obstetrics & Gynaecology Related Incident

40. ☐ Death of Fetus Weighing > 800g or 28 weeks of Gestation
41. ☐ Poor Apgar Score (Equal to or less than 5,6 and 7 at 1,5 and 10 minutes)
42. ☐ Injury to Neonate During Delivery
43. ☐ Mother Transferred to ICU Post-delivery
44. ☐ Unplanned Post-delivery Procedure
45. ☐ Infant Discharge to Wrong Person / Missing Infant

Page 1 of 7

13. ☐ Extravasation
14. ☐ Infection Control Related Incident: ESBL / MRSA etc.
15. ☐ Non-compliance of Policy and Procedure
16. ☐ Equipment Related Incident Occurred during Procedure
17. ☐ Sentinel Event (specify): ____________
18. ☐ Acupuncture Pneumothorax
19. ☐ Post Acupuncture Hematuria / Infection
20. ☐ Needle Unremoved

ICU/ HDU / CCU Related Incident

46. ☐ Accidentally Extubation / Cut Pressure Cuff Tube
47. ☐ Dislodgement of Catheter
48 ☐ Dislodgement of Tracheostomy
49. ☐ Re-admission to ICU within 24hrs of discharge to ward
50. ☐ Complication during stay in ICU
51. ☐ CRBSI / VAP Incident

NON-CLINICAL INCIDENTS

Operative / CSSD Related Incident

21. ☐ Cardiac / Respiratory Arrest
22. ☐ Wrong Procedure / Surgery Performed
23. ☐ Wrong Patient Operated Upon
24. ☐ Unplanned Return to the OR within 24hrs of Surgery
25. ☐ Prolonged Stay in Recovery Room for more than 2hrs
26. ☐ Improper Operative Consent / No Consent
27. ☐ Incorrect Instrument or Swab Count
28. ☐ Unintended Retained Foreign Body
29. ☐ Elective Surgery Cancelled in OR
30. ☐ Pre-operative Orders / Assessment not carried out
31. ☐ Re-intubation
32. ☐ No indicator at CSSD set
33. ☐ Missing CSSD item (specify): ____________

Safety / Security Related

52. ☐ Trapped in Elevator
53. ☐ Electric Shock
54. ☐ Hit by Object
55. ☐ Assault
56. ☐ Theft / Property Missing (specify): ____________
57. ☐ Damaged Article
58. ☐ Fire
59. ☐ Unauthorized Personnel
60. ☐ Patient Absconded / Abduction of patient (of any age)
61. ☐ Others (specify): ____________

Food and Beverages Related Incident

62. ☐ Physical Contamination in Food
63. ☐ Others (specify): ____________

Pest Control Related Incident:

64. ☐ Vermin Sighting Incident (specify): ____________
65. ☐ Others (specify): ____________

Engineering and Facilities Related Incident

66. ☐ Malfunction / Intentional or Accidental Misuse of Equipment
67. ☐ Facilities or Building Structured Damage / Broken

Miscellaneous

68. ☐ Billing Related incident (specify): ____________
69. ☐ Housekeeping (specify): ____________
70. ☐ Others (specify): ____________

Note: *All Safety related incidents must be reported to the Safety Officer immediately for any major incident or within 24 hours. All Major/ Sentinel Event must be reported to COO immediately.*

REPORTED TO:

SAFETY OFFICER:

Date / Time: ____________ / ____________

(Major / Sentinel Event) COO:

Date / Time: ____________ / ____________

Page 2 of 7

Narrative description of what had happened: *(Complete immediately if sentinel event, others within 24 hours. Please use separate paper if necessary)*

____

____

____

____

____

Name of person submitting report: ____________________

Signature : ____________________

Date : ____________________

Reviewed by HOD: ____________________

Signature : ____________________

Date : ____________________

IMMEDIATE OBSERVATION

Temperature: ______ **BP:** ________ **PR/HR:** _______ **SPO:** _____%

Resp: ____/min **RBS:** ______mmol/L **Pain score:** _____/10 **GCS** ____ /15

Remarks:

____

____

Inform Dr./ Practitioner: ____________________

Date & Time : ____________________

ASSESSMENT OF INJURY

- No apparent injury
- Burn / Scalded
- Broken teeth / Denture
- Contusion / Abrasion
- Fracture / Dislocation
- Redness
- Laceration / Perforation
- Swelling / Hematoma
- Soreness
- Strain / Sprain
- Others (specify): ____________

Seen by Dr. / Practitioner: ____________________

Date & Time called : ____________________

Date & Time Responded: ____________________

Treatment Ordered

X -ray	Yes	No
Neuro Chart	Yes	No

Others: ____________________

Explanation description by Attending Consultant / Medical Officer / Practitioner *(Where applicable)*

____

____

____

____

____

Name of Consultant / Medical Officer / Practitioner: ____________________ **Signature:** ____________________

Date :

SECTION B: To be completed by In-charge / Manager / Head of Department	
Incident Investigation including Root Cause (If two departments are involved, the particular HOD where the incident occurred will complete this section). Kindly attach all supporting evidence and reports.	
Corrective Action (s)	
Preventive Action (s)	
HOD 1: Name: ______________ Signature: ______________ Date: ______________	HOD 2 (If 2 departments are involved): Name: ______________ Signature: ______________ Date: ______________

SECTION C: Verification by Head of Division
Remarks / Comments
Name: ______________ **Signature:** ______________ **Date:** ______________
Designation: ______________ Department: ______________

SECTION D: Validation by QA Executive / Safety & Health Executive (compile all evidence — photograph, reports and etc.)		
Submission to MOH	Yes	No *(only applicable for specified sentinel event)*
Submission to DOSH	Yes	No
Availability of Evidence (s)	Yes	No
Remarks / Comments		
Name: ______________ **Signature:** ______________ **Department:** ______________		
Designation: ______________ **Date:** ______________		
Note: *QA Manager and Safety Officer to monitor and keep log of all incidents*		

Verification by Medical Affairs and Quality Manager

Remarks / Comments

____

Name: ____________________ **Signature:** ____________ **Department:** ____________

Designation: ____________________ **Date:** ____________

Case Solved: **Severity Assessment Code (SAC):** 1 2 3 4

Yes No

To follow up on: ____________________

SEVERITY ASSESSMENT CODE (SAC) MATRIX

	Minimum	Minor	Moderate	Major	Serious
Frequent	3	3	2	1	1
Likely	3	3	2	1	1
Possible	4	3	2	2	1
Unlikely	4	4	3	2	1
Rare	4	4	3	3	2

SECTION E: Acknowledgement by Chief Operating Officer and CEO / Medical Director / PIC

Remarks / Comments

____

____

____

____

____

Name (COO): ____________________ **Signature:** ____________ **Date:** ____________

Remarks / Comments

____

____

____

____

____

Name (CEO / Medical Director / PIC): ____________________ **Signature:** ____________ **Date:** ____________

APPENDIX 1 – CHRONOLOGY OF THE EVENT

DATE	TIME	EVENT	STAFF INVOLVE

Appendix O

HOSPITAL UNIVERSITI TUNKU ABDUL RAHMAN
Wholly owned by UTAR Education Foundation (Co. No. 202010105647578227-M])

PATIENT FEEDBACK FORM (患者反馈表)

Name (名字): Contact Number (电话号码):	Date (日期):
In which department of the hospital you have visited? : 您在本院就诊于那个部门呢? : ____________________________________	

Please rate our services in the table below.
(请您在以下的列表评价于我们的服务表现)

	Very Dissatisfied (非常不满意)	Dissatisfied (不满意)	Neutral (中立)	Satisfied (满意)	Very Satisfied (非常满意)
Overall Services (整体的服务)					
Overall facilities (整体的设施于设备)					
Overall cleanliness (整体的整洁)					
Overall condition of linen (医用布料整体上的质量)					
Overall food and diet services (医院整体的膳食服务)					
Courtesy of staff (工作人员的礼仪)					
Doctor's professionalism (医生的专业性)					
Nursing services (护士们的服务)					
Waiting time (等待的时间)					

Address: Hospital UTAR, Jalan Hospital UTAR, 31900 Kampar Perak Darul Ridzuan, Malaysia
Tel: (605) 462 0130 **Fax:** (605) 462 0133
Email: contact@utarhospital.org.my
Website: https://utarhospital.org.my

HOSPITAL UNIVERSITI TUNKU ABDUL RAHMAN
Wholly owned by UTAR Education Foundation (Co. No. 200201010564[578227-M])

Registration and payment process (登记与付费程序)					
Others, please specify, (若有其他的，请备注), ______________________					

Further recommendations / suggestions for improvement:
(若有更详细的建议，请在这列出)

____

____

____

____

____

____

What is the likelihood that you will return to UTAR Hospital?
(您会再次来到拉曼大学医院就诊吗?)

☐ Definitely will visit again (一定会再光临) ☐ Will consider (会考虑再光临) ☐ Not visiting again (不会再光临)

How likely you would recommend UTAR Hospital to a friend or relative?
(您会推荐朋友或亲人来到拉曼大学医院看诊吗?)

☐ Yes (会的) ☐ Will consider (会考虑) ☐ No (不会)

How do you know about Hospital UTAR?
(您是通过哪方知道拉曼大学医院的呢?)

☐ Family Members (家庭成员) ☐ Friends (朋友介绍) ☐ Social Media (社交平台) ☐ Hospital Activities (医院活动)

Others, please specify,
(若有其他的，请您备注),

____

Thank you very much for your feedback!
(非常感谢您的回馈与建议!)

Address: Hospital UTAR, Jalan Hospital UTAR, 31900 Kampar Perak Darul Ridzuan, Malaysia
Tel: (605) 462 0130 **Fax:** (605) 462 0133
Email: contact@utarhospital.org.my
Website: https://utarhospital.org.my

ACKNOWLEDGEMENT

This guideline was developed through a collaboration between the T&CM Division of the MOH and the UTAR T&CM Centre. The T&CM Division extends its appreciation to the Medical Development Division, Family Health Development Division, Perak State Health Department, and all other key stakeholders who provided constructive feedback and shared their expertise throughout the pilot project.

This guideline will be updated periodically to reflect the latest developments in the collaboration.

EDITORS

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