

Temporary Form for HSP Screening (For Clinics)

Please use this temporary form before entering the report into the HSP Portal *(if required)*

Patient Name:	
IC Number:	

Address (Line 1):			
Address (Line 2):			
Postcode:		Town:	
State:			
Telephone:			

Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	
Ethnic	<input type="checkbox"/> Malay <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Bumiputera Sarawak <input type="checkbox"/> Bumiputera Sabah <input type="checkbox"/> Others - Specify: _____		

Waist Circumference: (CM)		Weight: (KG)		Height: (Metres)	
--------------------------------------	--	---------------------	--	-------------------------	--

Pulse:		Blood Pressure: (Sys/Dia)	
---------------	--	--------------------------------------	--

1	Is patient a smoker?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Does the worker have any previous medical diseases?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, specify:
3	Does the worker know about his/her health condition before this screening?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Have the worker ever done a health screening prior to SOCSO's Health Screening Programme?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5	Does the worker have any disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, specify:
6	Does any of the worker's family members (first degree) suffer from Ischemic Heart Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7	Does any of the worker's family members (first degree) suffer from Renal Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8	Does any of the worker's family members (first degree) suffer from Diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9	Does any of the worker's family members (first degree) suffer from Hyperlipidemia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10	Does any of the worker's family members (first degree) suffer from any cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Occupation (Job Title)	
Occupational Classifications Please select one: <i>(Continue on next page)</i> <i>(Continue from previous page)</i>	<input type="checkbox"/> Managers <input type="checkbox"/> Professionals <input type="checkbox"/> Technicians and Associate Professionals <input type="checkbox"/> Clerical Support Workers <input type="checkbox"/> Service and Sales Workers <input type="checkbox"/> Skilled Agricultural, Forestry and Fishery Workers

	<input type="checkbox"/> Craft and Related Trades Workers <input type="checkbox"/> Plant and Machine-Operators and Assemblers <input type="checkbox"/> Elementary Occupations <input type="checkbox"/> Armed Forces Occupations
Occupational Hazards Multiple selection allowed:	<input type="checkbox"/> Physical <input type="checkbox"/> Biological <input type="checkbox"/> Psychosocial <input type="checkbox"/> Chemical <input type="checkbox"/> Ergonomic
Occupational Medical Surveillance	<input type="checkbox"/> Yes <input type="checkbox"/> No
Company's Industry Please select one:	<input type="checkbox"/> Agriculture, Forestry and Fishing <input type="checkbox"/> Mining and Quarrying <input type="checkbox"/> Manufacturing <input type="checkbox"/> Electricity, Gas, Steam and Air Conditioning Supply <input type="checkbox"/> Water Supply; Sewerage, Waste Management and Remediation Activities <input type="checkbox"/> Construction <input type="checkbox"/> Wholesale and Retail Trade; Repair of Motor Vehicles and Motorcycles <input type="checkbox"/> Transportation and Storage <input type="checkbox"/> Accommodation and Food Service Activities <input type="checkbox"/> Information and Communication <input type="checkbox"/> Financial and Insurance/Takaful Activities <input type="checkbox"/> Real Estate Activities <input type="checkbox"/> Professional, Scientific and Technical Activities <input type="checkbox"/> Administrative and Support Service Activities <input type="checkbox"/> Public Administration and Defence; Compulsory Social Security <input type="checkbox"/> Education <input type="checkbox"/> Human Health and Social Work Activities <input type="checkbox"/> Arts, Entertainment and Recreation <input type="checkbox"/> Other Service Activities <input type="checkbox"/> Activities of Households as Employers; Undifferentiated Goods-And Services-Producing Activities of Households For Own Use <input type="checkbox"/> Activities of Extraterritorial Organizations and Bodies

Mammogram (For Female Only) - Please enter the following info in Mammogram Voucher Record

Criteria A:		
1	The worker has a family history of breast cancer (mother, sisters or daughters ever had breast cancer)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	The worker is a carrier of BRCA1 or BRCA2?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
3	The worker has a history of atypia on breast biopsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Criteria B:		
4	The worker has no children or a first child after the age of 30 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5	The worker has her first menstrual period at the age of 12 years or younger?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6	The worker had her menopause after the age of 55 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
7	The worker is currently on hormone replacement therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8	BMI >= 27.5	<input type="checkbox"/> Yes <input type="checkbox"/> No

Mammogram Referral Recommendation:

Recommend for Mammogram Imaging if at least one (1) from Criteria A (Questions 1 to 3)

Or at least two (2) from Criteria B (Questions 4 to 8)