DATE :
PATIENT NAME :
WORKER CODE :

CLINIC NAME :
DOCTOR NAME :

MEDICAL CHECK-UP FOMEMA

PART I **MEDICAL HISTORY**

LMP : _____

Comments : _____

_____

_____

PART II **SYSTEM EXAMINATION**

	ABNORMAL	NORMAL
1. CARDIOVASCULAR SYSTEM		
2. RESPIRATORY SYSTEM		
3. GASTROINTESTINAL SYSTEM		
4. NERVOUS SYSTEM AND MENTAL STATUS		
5. GENITOURINARY SYSTEM		

PART III **PHYSICAL EXAMINATION AND INVESTIGATION**

1. HEIGHT : _____ CM
2. WEIGHT : _____ KG
3. PULSE : _____ PER MIN

4. BLOOD PRESSURE
Systolic: _____ mm. Hg
Diastolic: _____ mm. Hg

VISION TEST

		DEFECTIVE	NORMAL
Unaided	L		
	R		
Aided	L		
	R		
Hearing Ability	L		
	R		

PART IV **LABORATORY RESULT AND X-RAY FINDINGS**

Comments :

LAB : _____

_____

_____

X-RAY : _____

_____

_____

SIGNATURE WORKERS

PART V **CERTIFICATION BY DOCTOR**

	YES	NO
1. HIV / AIDS		
2. TUBERCULOSIS		
3. MALARIA		
4. LEPROSY		
5. SEXUALLY TRANSMITTED DISEASES		
6. HEPATITIS		
7. CANCER		
8. EPILASY		
9. PSYCHIATRIC ILLNESSV		
10. She is pregrant		
11. His / Her urine contains opiates		
12. His / Her urine contains cannabis		

13. I THEREFORE CERTIRY THAT HE / SHE IS FOR EMPLOYMENT	**UNFIT**	**FIT**

IF CONSIDERED <u>NOT FIT</u> FOR EMPLOYMENT PLEASE STATE THE REASON

_____

_____

_____

PART VI **OUTCOME (To be completed by the Doctor)**

	NO	YES	DATE
1. Health Office is being notified			_____
2. I am referring the case to Government Hospital. (e.g. mental illness, etc)			_____
3. I am referring the case to a prive Hospital.			_____
4. I am treating the patient.			_____
5. The patient is still undergoing Treatment.			_____

_____

Signature and Name of the Doctor

FOREIGN WORKER CONSENT, AUTHORISATION

AND DECLARATION FORM

This is to confirm that I, _____
(Name of Foreign Worker)

Worker's code _____ passport number _____
(Worker's code) *(Passport No.)*

hereby irrevocably consent and authorise Dr. _____
(Doctor's Name)

of _____ to:-
(Name of clinic)

i. carry out a medical examination on me including the testing of blood and urine and the taking of chest x-ray as required by the FOMEMA screening programme, and

ii. disclose my health report / records and any other health information to FOMEMA Sdn. Bhd., the Ministry of Health, the Immigration Department, employer and any other relevant authorities, as and when it is required to do so.

I also hereby confirm the following:

i. I have not taken/ taken * (*if taken, please specify*) any medication / drugs within the last two (2) weeks,

(a)_____ (b)_____(c)_____

ii. My last menstrual period was on ____ / ____ / _____ (DD/MM/YY).

_____ _____
Signature or thumbprint of Foreign Worker Date

Witnessed by:

_____ _____
Signature of Examining Doctor Name of Examining Doctor

_____
Clinic's Stamp

FOMEMA X-RAY REPORT

Name of Foreign Worker : _____

Worker Code : _____ Date of report : _____

	Abnormal	Normal	Details of abnormality
1. Thoracic Cage			
2. Heart Shape and Size (CTR if applicable)			
3. Lung Fields			
4. Mediastinum and hila			
5. Pleura / Hemidiaphragms / costopherenic angles			
	Yes	No	
6. Focal lesion (e.g. PTB (old / new), maglinancy, etc.)			
7. Any other abnormalities			
IMPRESSION :			

....

Signature and Name of reporting GP Radiologist Clinc Stamp