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 pregnant		
11.	His / Her urine contains opiates		
12.	His / Her urine contains cannabis		

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

IF CONSIDERED NOT FIT 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

Appendix 2

CONCENT & AUTHORISATION BY FOREIGN WORKER

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 reports / records and any other health information to Fomema Sdn Bhd, the Ministry of Health Malaysia, the Immigration Department and any other relevant authorities, as and when it is required to do so.

_____________________________ _________________
Signature of thumbprint of Foreign Worker Date

Withnessed by

________________________ ____________________
Signature of Examining Doctor Name of Examining Doctor

____
Clinic 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