



Ministry of Health Malaysia

Malaysian DRG

"Shaping Healthcare Transformation Using Malaysian DRG"

<http://www.moh.gov.my/casemix/>



DIAGNOSIS CLINICAL DOCUMENTATION IN PER PD301

MORTALITY

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SAME CONCEPT WITH MORBIDITY: MAIN DIAGNOSIS

- The condition, **diagnosed at the end of the episode of health care**, primarily responsible for the patient's need for treatment or investigation.
- If there is more than one such condition, the one held **most responsible for the greatest use of resources** should be selected.
- **If no diagnosis was made, the main symptom**, abnormal finding or problem should be selected as the main condition.

OTHER DIAGNOSIS(CO-MORBIDITY)

- A disease that accompanies the main diagnosis and requires treatment and additional care, in addition to the treatment provided for the condition for which the patient was admitted
- **COMPLICATION DIAGNOSIS**
- **A disease that appears during the episode of care, due to a pre-existing condition or arising as a result of the care received by the patient**

Secondary diagnosis/diagnosis lain-lain Other conditions are defined as those conditions that **coexist or develop during the episode of health care and affect the**

EXTERNAL CAUSES OF INJURY AND POISONING

- The circumstances of the accident or violence which produced the fatal injury

GENERAL INFORMATIONS TO CONSIDER IN DOCUMENTING DIAGNOSIS

- **To identify the** underlying causative agent (i.e: organism, drugs, chemical, allergens, idiopathic, autoimmune)
- • **To specify site (anatomical localisation) of involvement and side (i.e: Left or/and right)**
- • **To indicate if the condition is acute/sub-acute/chronic, recurrent/persistent or mild/moderate/severe**
- • **To mention if the condition is congenital/acquired, primary/secondary or infantile/juvenile**

- • To mention laboratory findings i.e: Haematological, biopsy, histological (i.e: Sputum positive/negative pulmonary tuberculosis)
- • To specify the diagnosis failing which to specify symptoms and signs or reason for encounter/admission
- (i.e: Admitted for blood transfusion due to anaemia with underlying Thalassaemia, admitted for chemotherapy with underlying breast carcinoma, infant of diabetic mother admitted for observation, baby born before arrival for observation)

- **SPECIFIC INFORMATIONS** TO
CONSIDER IN DOCUMENTING
DIAGNOSIS

A. CERTAIN INFECTIOUS AND PARASITIC DISEASES

- Main diagnosis/underlying cause shall include:
- 1) **General infection**
- **To specify the causative agent**
- To mention condition (i.e: Meningitis, acute gastroenteritis) or site (pulmonary tuberculosis)
- **To include complication where necessary** (i.e: Cerebral malaria, rupture spleen, etc)
- **Other diagnosis • To mention antibiotic resistance if present** (i.e: Methicillin-resistant staphylococcus aureus, vancomycin resistant, etc)

2) Tuberculosis

- **To specify site involved** (i.e: Lung, spine, intestine, etc)
- **To mention method of confirmation** (i.e: Smear, culture or histology)

3) Viral hepatitis

- To specify acute or chronic
- To **specify type of virus** (i.e: Hepatitis A virus, hepatitis B virus, hepatitis C virus or hepatitis E virus)
- To mention complication with or without hepatic coma.
- **If hepatitis B to mention with or without delta agent** (co-infection)

B. PREGNANCY, CHILDBIRTH AND THE PUERPERIUM

- **Main diagnosis/underlying cause shall include:**

1) Pregnancy

- • **Specify types of abortion/miscarriage** (i.e: incomplete, complete, inevitable, etc)
- • **Specify the site of ectopic pregnancy** (i.e: Tubal, ovarian, abdominal, etc)
- • **Specify site of infection** (i.e: Vaginal candidiasis in pregnancy, etc)
- • **Specify pregnancy-related conditions** and complications (i.e: Pregnancy-induced hypertension, gestational diabetes mellitus, deep vein thrombosis complicating pregnancy, etc)

2) Delivery and Childbirth

- **Specify method of delivery** (i.e: Spontaneous vertex delivery, assisted vacuum delivery, elective lower segment caesarean section)
- **Specify number of fetus** (i.e: Single, twin, etc)
- **Relevant complications during delivery**

3) Puerperium

- **Specify complications** related to post partum period (i.e: Post partum haemorrhage due to puerperal sepsis)

C. CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD

Main diagnosis/underlying cause shall include:

- • If neonatal jaundice, must **specify the cause of jaundice** (i.e: Neonatal jaundice due to ABO incompatibility)
- • **If baby is premature, to mention the gestational age and weight**
- • If injury, **to indicate the site and either due to birth trauma** or other causes (please specify) (i.e: Subarachnoid hemorrhage due to birth injury or subarachnoid hemorrhage due to fall from bed)

- If birth asphyxia, to mention the APGAR score at 1 minute and 5 minute
- If baby admitted for observation indicate the condition/suspected condition
- To associate mother's condition during pregnancy that affect the baby with the reason for admission, treatment or observation

D. NEOPLASMS

- Main diagnosis/underlying cause shall
- **Specify primary or secondary site**
- **Specify site of organ involved** (i.e: Middle lobe of the right lung, right upper quadrant of right breast)
- **Specify behaviour** (i.e: Malignant primary, in-situ, benign, malignant secondary)
- **Specify morphology** (i.e: Squamous cell carcinoma)
- **Specify metastasis**

E. ENDOCRINE, NUTRITIONAL AND METABOLIC DISEASES

- Main diagnosis/underlying cause shall include:

1) Endocrine

Disorder of gland:

- • **To specify congenital or acquired.**
- • **To specify condition** (i.e: Thyrotoxicosis, hypopituitarism)
- • If thyroid gland involved, to specify with (diffuse, multinodular or single nodular) or without goiter.

- • If condition is due to drug-induced, to specify the name of drug.
- If diabetes mellitus:
 - • To specify the type i.e: Insulin dependant (Type I, juvenile-onset, etc) or non-insulin dependant
 - (Type II, adult onset, etc)
 - • To specify complication (i.e: Hyperosmolar Hyperglycaemic State (HHS) with coma, diabetic ketoacidosis, renal complication, etc)
 - • *Uncontrolled/unstable diabetes mellitus is referring to Type I

F. MENTAL AND BEHAVIOURAL DISORDERS

- *There is no issue in documenting diagnosis related to mental and behavioural disorder other than psychoactive substance used/abused
- **Main diagnosis/underlying cause shall**
- Indicate the psychoactive substances used/abused (i.e: Alcohol, opioids, cannabinoids, sedative or hypnotics, cocaine, tobacco, volatile solvents, hallucinogens, other stimulants)

- **Mention the mental and behavioural disorders due to the psychoactive substance used/abused** (i.e: Acute intoxication, harmful use, dependence syndrome, withdrawal state, withdrawal state with delirium, psychotic disorder, amnesic syndrome, residual and late-onset psychotic disorder)
- **Specify the severity of mental retardation** (i.e: Mild, moderate, severe, profound)
- **Indicate the extent of behavioural impairment** (i.e: No impairment, minimal impairment, significant impairment)

LABORATORY FINDINGS NOT ELSEWHERE CLASSIFIED

- **Should ONLY be used as main diagnosis if:**
 - **Cases for which no specific diagnosis can be made** even after all the facts bearing on the case have been investigated or for any other reason (i.e: Facility not available, patient refuse for investigation, etc)
 - **Signs or symptoms existing at the time of initial encounter** that proved to be transient and which causes could not be determined
 - **Cases referred elsewhere** for investigation or treatment before the diagnosis was made.

H. INJURY, POISONING AND CERTAIN OTHER CONSEQUENCES OF EXTERNAL CAUSES

The diagnosis pertaining to this topic must specify the external cause

- 1) Injury: Main Diagnosis/underlying cause shall include:
- Specify type of injury (i.e: Fracture, dislocation, wound, internal organ injury)
- Specify site of injury
- If fracture, to mention if open or close
- If internal injury occurs, to specify blunt or penetrating injury

I. **External cause of injury** shall include:

- **Patient's mode of transport** (i.e: Pedestrian, motorcycle, car, etc)
- Patient's role (i.e: Rider/driver or passenger)
- **Mechanism of injury** (i.e: Collision with car, non-collision (skidded, roll-over, etc.), fall, assault, etc)
- **Place of occurrence** (i.e: School, home, road, highway, field, etc)
- **Activity** (i.e: Sports, work, etc)
- **Intention of the event** (i.e: Accidental, self-harm, assault)

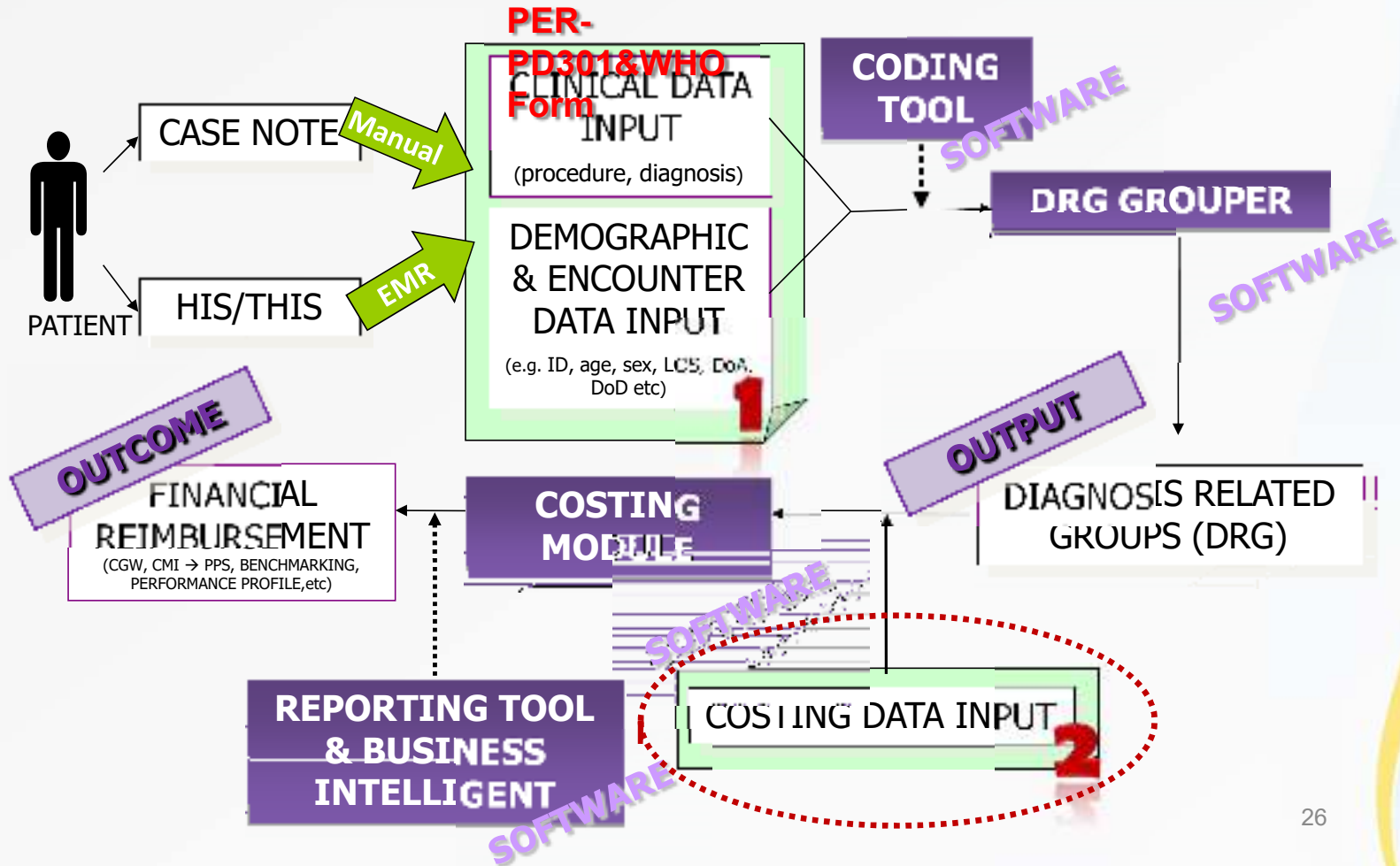
2) Burn/corrosion:

- Main diagnosis shall include
 - **The degree of burn**
 - **Specific site** of burn
 - **Percentage of body surface area** 28
- External cause of injury shall include:
 - **Mechanism of burn** (i.e: Thermal or chemical)
 - **Place of occurrence** (i.e: Home, workplace, etc)
 - **Activity** (i.e: Cooking, working, etc)
 - Intention of the event (i.e: Accidental, self-harm, assault, etc)

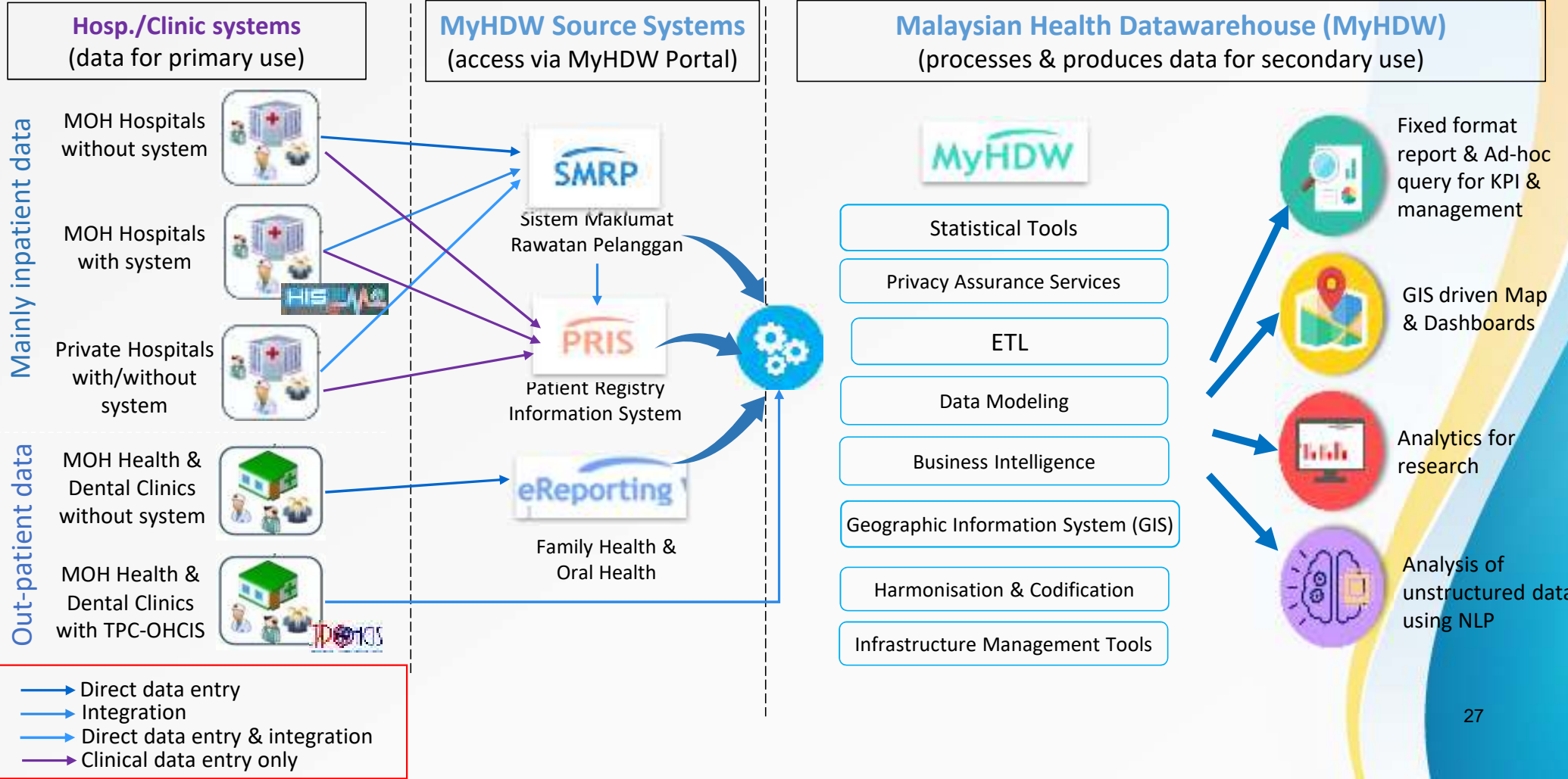
3) Poisoning

- Main diagnosis shall
- **Specify type of poison** (i.e: Drug, chemical, medicament)
- External cause of poisoning shall include:
- **The intention of event** (i.e: Accidental, suicide, homicide, adverse effect in therapeutic use)
- **Place of occurrence** (i.e: Home, workplace, etc)

Case-mix System Work Flow

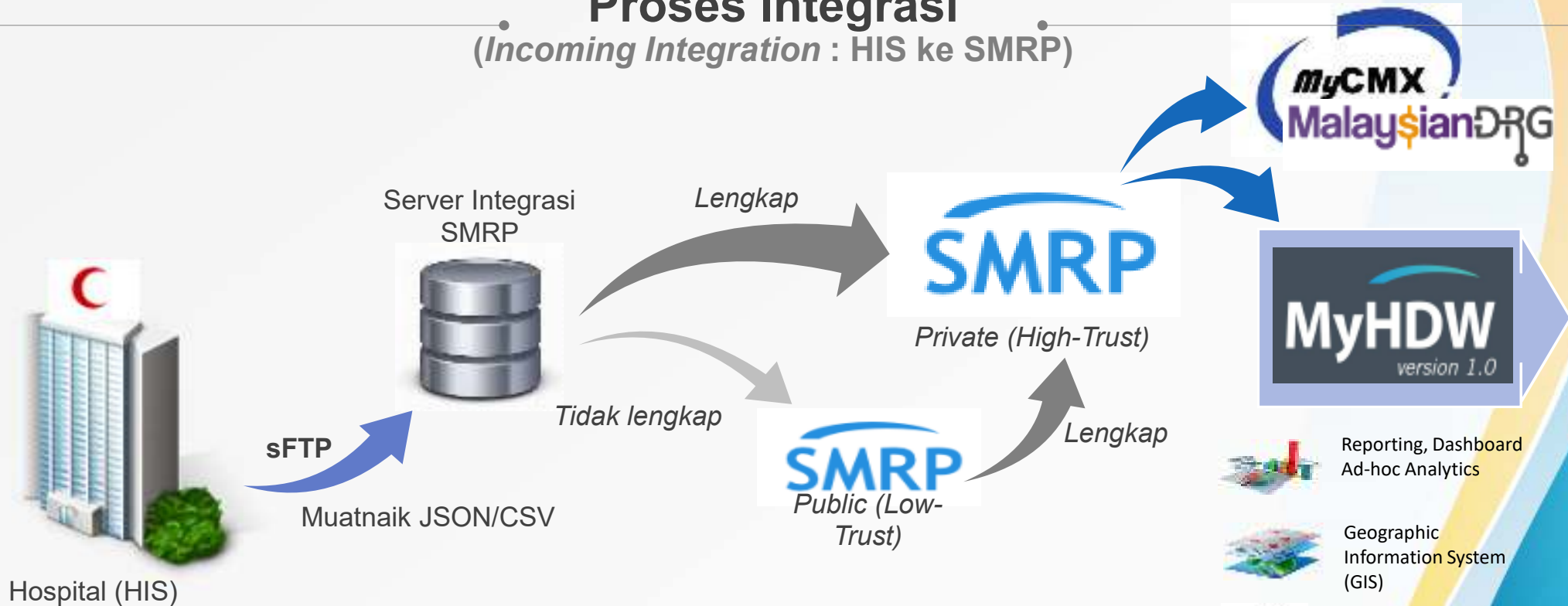


PROSES KESELURUHAN MyHDW



Proses Integrasi

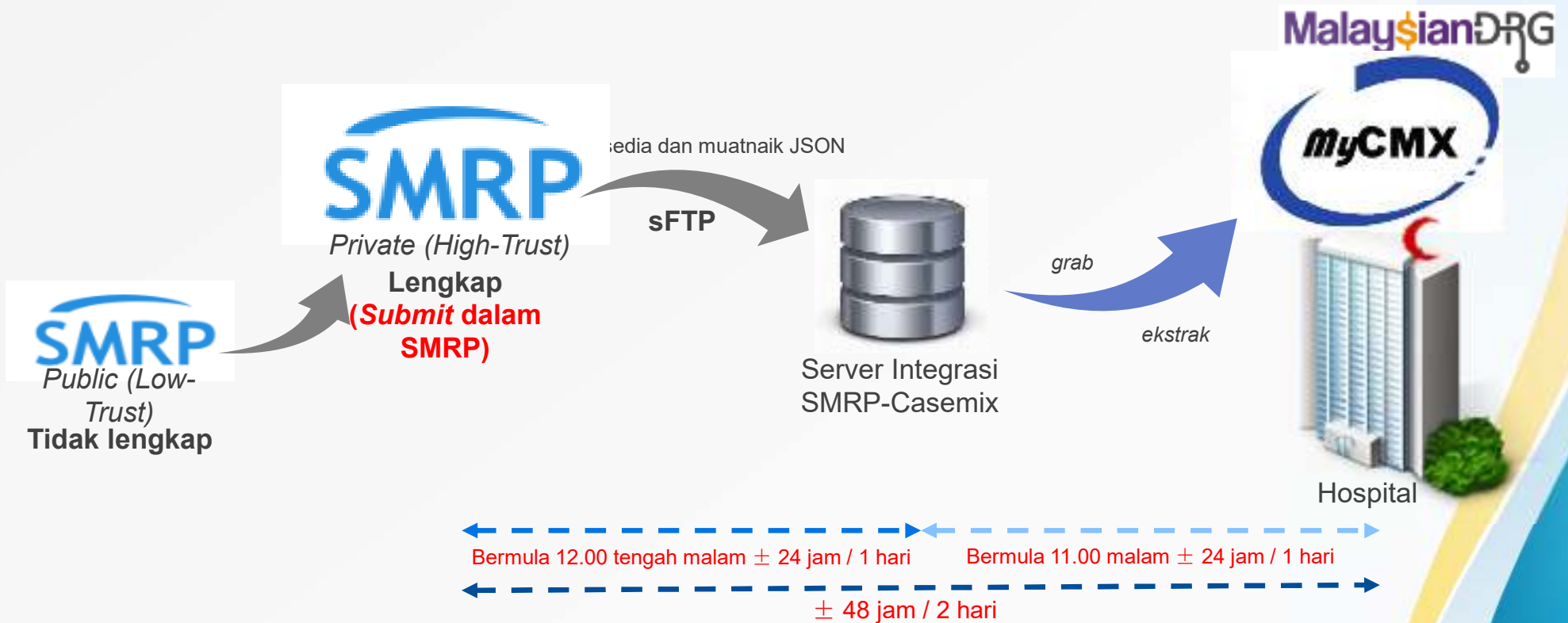
(Incoming Integration : HIS ke SMRP)



- Kaedah integrasi: melalui *Secure File Transfer Protocol* (sFTP).
- Setiap Hospital akan diberikan akses ke akaun sFTP untuk muat naik fail JSON/CSV.
- Fail integrasi diproses setiap hari pada masa yang ditetapkan.

Proses Integrasi **Semasa**

(Outgoing Integration : SMRP ke Casemix)



- Kaedah integrasi : penghantaran data melalui *Secure File Transfer Protocol* (sFTP).
- Fail integrasi diproses setiap hari mengikut jadual pada masa yang ditetapkan.
- **Hanya data lengkap dan telah *submit* dalam SMRP yang akan dialirkan ke sistem Casemix**

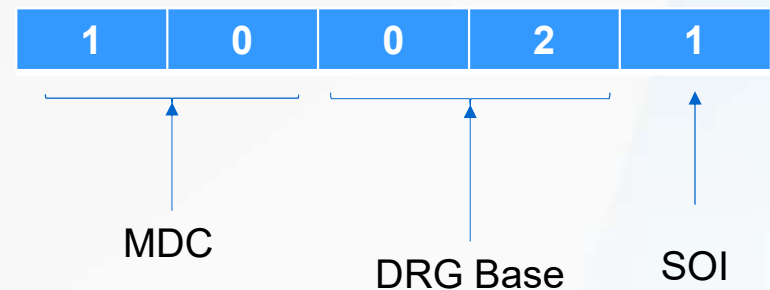
CLINICAL INFORMATION WORKFLOW

important

MALAYSIAN DRG NUMBERING SYSTEM

Diagnosis Related Group (DRG)

- Major Diagnostic Category (MDC)
 - 23 Main Groups
- DRG Bases
 - Inpatient : 273
- Severity Of Illness (SOI)
 - 1 : Without Co-morbidity & Complication (W/O CC)
 - 2 : With Co-morbidity & Complication (W CC)
 - 3 : With Major Co-morbidity & Complication (W MCC)
- Total Inpatient DRG
 - 819



CASE MIX SYSTEM

Diagnosis & Procedures for one episode of care

- SOI - main diagnosis
 - secondary diagnosis (complications & co-morbidity)
 - OT/non OT procedures
 - Age, sex
 - LOS
 - Discharge status

DRG

REIMBURSEMENT

Health Information FLOW

- History
- Examination
- Investigations
- Diagnosis Formation
- Management & Plan
- Discharge

Documentation in clinical case notes

- Documentation
 - Diagnosis
 - Procedures



- Professionally Trained Coders in Medical Records Department
- Coding
 - ICD-10 (for diagnosis)
 - ICD9CM (for procedures)

Medical Records Department



MyHDW

Type of Case Grouping	Data Requirements	Data Sources
<p>Diagnosis-based case grouping</p>	<p>Department average cost per bed-day, department lengths of stay, and other characteristics of the hospital or case</p>	<p>Hospital budgets and cost-accounting statistical data; individual data on age, sex, ICD-9 or ICD-10 code for primary diagnosis, length of stay, surgery, and other characteristics of the case (such as intensive care)</p>
<p>Department case grouping</p>	<p>Department average cost per bed-day; department lengths of stay</p>	<p>Hospital budgets and cost-accounting analysis; statistical data; other hospital expenditure and utilization data</p>
<p>No case grouping</p>	<p>Average cost per hospital case</p>	<p>Historical hospital budgets;</p>

BORANG DAFTAR MASUK DAN KELUAR HOSPITAL

PER-PPD/301
(Rev. 2019B)

1. NAMA LAYANAN / ALIHIR HIMPUNAN WALAH (KAWA)		2. NO. DAN NAMA ASYAN / WARD/ROOM (DOKTER)	
3. ALAMAT ORANG: KIL. PULAU KEMUNDI, 15300 KOTA KAYU, KRI. AWANG		4. NO. ORG. PERENCANAAN: 008530035414 (KANTOR PERENCANAAN)	
5. NO. IDENTIFIKASI: 815 5280003	6. JENIS: FEMALE	7. UMUR (TAHUN): 25 TAHUN	8. JENIS: 25 YRS
9. NAMA TAYANG (PUNYAN): MARIANNA MELAWI			

BORANG DAFTAR MASUK DAN KELUAR HOSPITAL

(PER-PD 301)

10. JENIS PERIKSAAN	11. JENIS PERIKSAAN	12. JENIS PERIKSAAN	13. JENIS PERIKSAAN
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**DIAGNOSIS DOCUMENTATION
FOR
MORTALITY CASE**



<p>IV. IZANIN (KAWA) KAWA: (Cause of Death)</p> <p>IV. IZANIN (KAWA) KAWA: (Cause of Death)</p>	<p>IV</p>
<p>IV. IZANIN (KAWA) KAWA: (Cause of Death)</p> <p>IV. IZANIN (KAWA) KAWA: (Cause of Death)</p>	<p>IV</p>
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<p>IV. IZANIN (KAWA) KAWA: (Cause of Death)</p> <p>IV. IZANIN (KAWA) KAWA: (Cause of Death)</p>	<p>IV</p>

All those diseases, morbid conditions or injuries which either resulted in or contributed to death and the circumstances of the accident or violence which produced any such injuries (Column II)

(a) The disease or injury which initiated the train of morbid events leading directly to death, or (b) the circumstances of the accident or violence which produced the fatal injury (Column III)

FIGURE 1

INTERNATIONAL FORM OF MEDICAL CERTIFICATE OF CAUSE OF DEATH

	Cause of death	Sebab-sebab kematian (Kolum II)
I		
Disease or condition directly leading to death *	(a) due to (or as a consequence of)	
Antecedent causes	(b) due to (or as a consequence of)	
Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(c) due to (or as a consequence of)	
	(d) due to (or as a consequence of)	
<hr/>		
II		Sebab-sebab yang menyebabkan (Kolum III)
Other significant conditions contribution to the death, but not related to the disease or condition causing it	

** This does not mean the mode of dying, e.g. heart failure, respiratory failure. It means the disease, injury, or complication that caused death.*

	Cause of death	Approximate interval between onset and death
<p>I</p> <p>Disease or condition directly leading to death *</p> <p>Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last</p>	<p>(a) Hepatic Failure due to (or as a consequence of)</p> <p>(b) Bile duct obstruction due to (or as a consequence of)</p> <p>(c) Carcinoma of head of pancreas due to (or as a consequence of)</p> <p>(d) due to (or as a consequence of)</p>	
<p>II</p> <p>Other significant conditions contribution to the death, but not related to the disease or condition causing it</p>	<p>.....</p> <p>.....</p>	<p>.....</p> <p>.....</p>
<p>* This does not mean the mode of dying, e.g. heart failure, respiratory failure. It means the disease, injury, or complication that caused death.</p>		

	Cause of death	Approximate interval between onset and death
<p>I</p> <p>Disease or condition directly leading to death *</p> <p>Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last</p>	<p>(a) Traumatic shock due to (or as a consequence of)</p> <p>(b) Multiple fractures due to (or as a consequence of)</p> <p>(c) Pedestrian hit by truck (traffic accident) due to (or as a consequence of)</p> <p>(d) due to (or as a consequence of)</p>	
<p>II</p> <p>Other significant conditions contribution to the death, but not related to the disease or condition causing it</p>	<p>.....</p> <p>.....</p>	<p>.....</p> <p>.....</p>
<p><i>* This does not mean the mode of dying, e.g. heart failure, respiratory failure. It means the disease, injury, or complication that caused death.</i></p>		

Certain infection and parasitic diseases

1) GENERAL INFECTION

- TO **SPECIFY THE CAUSATIVE AGENT**
- TO MENTION CONDITION (I.E : MENINGITIS, ACUTE GASTROENTERITIS) OR SITE (PULMONARY TUBERCULOSIS)
- TO **INCLUDE COMPLICATION** WHERE NECESSARY

MAIN DIAGNOSIS	EXAMPLE 1 GROUP A STREPTOCOCCAL (CAUSATIVE AGENT) SEPTICEMIA (CONDITION)
	EXAMPLE 2 HIV (CAUSATIVE AGENT) DISEASE WITH CANDIDIASIS (COMPLICATION)
OTHER DIAGNOSIS	HYPERTENSION DIABETES MELLITUS
MAIN	BLOOD CULTURE & SENSITIVITY

2) TUBERCULOSIS

- TO **SPECIFY SITE** INVOLVED (I.E : LUNG, SPINE, INTESTINE, ETC)
- TO MENTION **METHOD OF CONFIRMATION** (I.E : SMEAR, CULTURE OR HISTOLOGY)

MAIN DIAGNOSIS	SMEAR POSITIVE (METHOD OF CONFIRMATION) PULMONARY (SITE) TUBERCULOSIS
OTHER DIAGNOSIS	NON-INSULIN DEPENDENT DIABETES MELLITUS WITHOUT COMPLICATION
MAIN PROCEDURE/SURGERY	SPUTUM ACID FAST BACILLI (AFB), CHEST X-RAY

NEOPLASMS

- SPECIFY PRIMARY OR SECONDARY SITE
- **SPECIFY SITE OF ORGAN INVOLVED** (I.E: MIDDLE LOBE OF THE RIGHT LUNG, RIGHT UPPER QUADRANT OF RIGHT BREAST)
- **SPECIFY BEHAVIOUR** (MALIGNANT, BENIGN)
- SPECIFY **MORPHOLOGY** (I.E : SQUAMOUS CELL CARCINOMA)
- **SPECIFY METASTASIS**

MAIN DIAGNOSIS	ADENOCARCINOMA (MORPHOLOGY/BEHAVIOUR) OF HEAD OF PANCREAS (SITE) WITH METASTASIS TO THE LIVER (METASTASIS)
CO-MORBID	CHRONIC PANCREATITIS
OTHER DIAGNOSIS	TYPE II DIABETES MELLITUS

Special Instruction for Cancer

1. If the cancer is still present **Cases**

MAIN DIAGNOSIS: Cancer

SECONDARY DIAGNOSIS: **any treated complications,** secondary/metastatic cancer or elective investigation/procedure/treatment.

2. If cancer has been removed :

MAIN DIAGNOSIS: Any subsequent elective investigation/procedure/ treatment.

SECONDARY DIAGNOSIS:.....(cancer post procedure)

3. **If cancer has been removed but patient is undergoing elective admission for secondary/metastatic cancer :**

MAIN DIAGNOSIS: Secondary/ metastatic cancer

SECONDARY DIAGNOSIS: Elective investigation/procedure/treatment
+ history of ... (Primary cancer)

<p>27. DIAGNOSA (DIAGNOSIS) :</p> <p>I) DIAGNOSIS UTAMA <i>(Disease Or Condition Directly Leading To Death)</i> Elective admission for 2nd cycle of chemotherapy</p>	<p>28. NOMBOR KOD</p> <p>i)</p>
<p>II) SEBAB-SEBAB KEMATIAN <i>(Cause Of Death)</i></p>	<p>II)</p>
<p>III) SEBAB-SEBAB YANG MENYEBABKAN (UNDERLYING CAUSE) <i>(Disease or condition leading to death) DUE TO OR AS A CONSEQUENCES OF</i></p>	<p>III)</p>
<p>IV) DIAGNOSIS LAIN (CO-MORBIDITY, jika ada) <i>(Antecedent causes giving rise to the above cause) DUE TO OR AS A CONSEQUENCES OF</i> Malignant neoplasm of sigmoid colon</p>	<p>IV)</p> <p>C18.7</p>
<p>V) DIAGNOSIS LAIN Essential (primary) hypertension Non-insulin-dependent diabetes mellitus without complications</p>	<p>V)</p> <p>I10 E11.9</p>
<p>VI) DIAGNOSIS KOMPLIKASI (jika ada)</p>	<p>VI)</p>
<p>VII) SEBAB-SEBAB LUARAN KECEDERAAN & KERACUNAN (External Causes Of Injury & Poisoning)</p>	<p>VII)</p>
<p>VIII) FAKTOR-FAKTOR LAIN YANG MEMPENGARUHI TARAF KESIHATAN & KONTEK DENGAN PERKHIDMATAN KESIHATAN <i>(Antecedent causes giving rise to the above cause) DUE TO OR AS A CONSEQUENCES OF</i></p>	<p>VIII)</p>

ENDOCRINE & METABOLIC DISEASES

DISORDER OF GLAND :

- TO SPECIFY CONGENITAL OR ACQUIRED
- TO SPECIFY CONDITION (I.E : THYROTOXICOSIS, HYPOPITUITARISM)
- IF THYROID GLAND INVOLVED, TO SPECIFY WITH (DIFFUSE, MULTINODULAR OR SINGLE NODULAR) OR WITHOUT GOITRE

IF DIABETES MELLITUS :

- SPECIFY TYPE I.E : INSULIN DEPENDENT (TYPE I, JUVENILE ONSET) OR NON-INSULIN DEPENDENT (TYPE II, ADULT ONSET)
- TO SPECIFY COMPLICATION (I.E : HHS WITH COMA, DKA, RENAL, OPHTHALMIC, NEURO)

DIABETES MELLITUS..

- Type of DM (E10 -14)
- **Specify complications** (4th character) :
 - Coma (.0)
 - Ketoacidosis (.1)
 - Renal (.2)
 - Ophthalmic (.3)
 - Neurological (.4)
 - Peripheral circulatory complication (.5)
 - Other specified complications (.6)
 - Multiple complications (.7)
 - Unspecified complications (.8)
 - Without complications (.9)



CODES FOR PRIMARY HYPERTENSION

Hypertension	Heart Disease	Heart failure*	Kidney disease*	ICD-10 code
Yes	No	No	No	I10 Essential (primary) hypertension
Yes	Yes	No	No	I11.9 Hypertensive heart disease without HF
Yes	Yes	Yes*	No	I11.0 Hypertensive heart disease with HF
Yes	No	No	Yes**	I12.9 Hypertensive CKD with stage 1 - 4 CKD or unspecified CKD
Yes	No	No	Yes**	I12.0 Hypertensive CKD with stage 5 CKD or ESRD
Yes	Yes	Yes*	Yes**	I13.0 Hypertensive heart and CKD with HF and with stage I-4 CKD or unspecified CKD
Yes	Yes	Yes*	Yes**	I13.2 Hypertensive heart and CKD with HF and with stage 5 CKD or ESRD
Yes	Yes	No	Yes**	I13.10 Hypertensive heart and CKD without HF and stage 1-4 CKD or unspecified CKD
Yes	Yes	No	Yes**	I13.11 Hypertensive heart and CKD without HF and with stage 5 CKD or ESRD

PREGNANCY, CHILDBIRTH AND PUERPERIUM

1) PREGNANCY

- SPECIFY TYPES OF ABORTION/MISCARRIAGE (INCOMPLETE, COMPLETE, INEVITABLE)
- SPECIFY SITE OF ECTOPIC PREGNANCY (TUBAL, OVARIAN, ABDOMINAL)
- SPECIFY SITE OF INFECTION (VAGINAL CANDIDIASIS IN PREGNANCY)
- SPECIFY **PREGNANCY RELATED CONDITIONS AND COMPLICATIONS** (GESTATIONAL HYPERTENSION, GESTATIONAL DIABETES MELLITUS, DVT COMPLICATING PREGNANCY)

MAIN DIAGNOSIS	VAGINAL CANDIDIASIS (SITE OF INFECTION) IN PREGNANCY
CO-MORBID	INSULIN DEPENDENT GESTATIONAL DIABETES MELLITUS (PREGNANCY RELATED CONDITION)

2) DELIVERY AND CHILDBIRTH

- SPECIFY **METHOD OF DELIVERY** (I.E : SVD, VAD, LSCS)
- SPECIFY **OUTCOME OF DELIVERY** (I.E : SINGLE, TWIN, ETC)
- RELEVANT **COMPLICATIONS DURING DELIVERY**

MAIN DIAGNOSIS	SPONTANEOUS VERTEX DELIVERY (METHOD OF DELIVERY) WITH 3 RD DEGREE PERINEAL LACERATION (COMPLICATION DURING DELIVERY)
CO-MORBID	GESTATIONAL DIABETES MELLITUS
OTHER DIAGNOSIS	SINGLE LIVE BIRTH (OUTCOME OF DELIVERY)
MAIN PROCEDURE/SURGERY	PERINEAL REPAIR

CONDITIONS ORIGINATING IN PERINATAL PERIOD

- **If neonatal jaundice, must specify the cause** (i.e : neonatal jaundice due to abo incompatibility)
- **If baby is premature, to mention gestational age and weight**
- If injury, to indicate site and either due to birth trauma or other causes (i.e : subarachnoid hemorrhage due to birth injury or subarachnoid hemorrhage due to fall from bed)
- **If baby admitted for observation, indicate the condition/suspected condition**
- To associate mother's condition during pregnancy that affect the baby with the reason for admission, treatment or observation

NEONATAL JAUNDICE

POSSIBLE DIAGNOSIS DESCRIPTION	ICD 10 CODE
Physiological jaundice / Prolonged NNJ	P59.9
NNJ secondary to ABO incompatibility	P55.1
NNJ secondary to Rhesus incompatibility	P55.0
NNJ secondary to Polycythaemia	P58.3
NNJ secondary to infection	P58.2
NNJ secondary to prematurity	P59.0
NNJ secondary to Cephalohaematoma/ Subaponeurotic Haemorrhage	P59.8
Breastfeeding jaundice	P59.8
Breastmilk jaundice	P59.3

DISORDERS RELATED TO PRETERM BABIES AND FETAL GROWTH

POSSIBLE DIAGNOSIS DESCRIPTION	ICD 10 CODE
Extreme low birth weight (BW < 999 g)	P07.0
Other low birth weight (1000-2499 g)	P07.1
Extreme prematurity (< 28 weeks)	P07.2
Other preterm infants (28-37 weeks)	P07.3
Small for gestational age (SGA) – below 10 th centile	P05.1
Large for gestational age (LGA) – BW >4000g	P08.1

BIRTH TRAUMA

POSSIBLE DIAGNOSIS DESCRIPTION	ICD 10 CODE
Intracranial/ Intracranial Haemorrhage due to birth injury	P10.1
Intraventricular Haemorrhage due to birth injury	P10.2
Subarachnoid Haemorrhage due to birth injury	P10.3
Cephalohaematoma	P12.0
Bruising of scalp due to birth injury	P12.3
Skull fracture due to birth injury	P13.0
Fracture of clavicle due to birth injury	P13.4

RESPIRATORY DISORDERS SPECIFIC TO PERINATAL PERIOD

POSSIBLE DIAGNOSIS DESCRIPTION	ICD 10 CODE
Transient Tachypnoea of Newborn (TTN)	P22.1
Respiratory Distress of Newborn (RDS)	P22.0
Meconium Aspiration Syndrome (MAS)	P24.0
Persistent Pulmonary Hypertension of Newborn (PPHN)	P29.3
Neonatal Aspiration of milk and regurgitation	P24.3
Pneumothorax	P25.1
Congenital Pneumonia (Specify Organism)	P23._

FOETUS AND NEWBORN AFFECTED BY MATERNAL CONDITION

POSSIBLE DIAGNOSIS DESCRIPTION	ICD 10 CODE
Fetus affected by Premature Rupture of Membrane	P01.1
Fetus affected by maternal cervical incompetence	P01.0
Fetus affected by placenta praevia	P02.0
Fetus affected by prolapsed cord	P02.4
Fetus affected by chorioamnionitis	P02.7
Fetus affected by cord compression – cord round neck, knot in cord	P04.5
Malpresentation – breech, transverse lie, unstable lie	P01.7

INJURY CASES

Main diagnosis / underlying cause shall include :

- **Specify type of injury** (Fracture, dislocation, wound)
- **Specify site of injury**
- **If fracture, to mention if open or close**

External cause of injury shall include :

- **Patient's mode of transport** (Pedestrian, motorcycle, car)
- **Patient's role** (Rider/driver or passenger)
- **Mechanism of injury** (Collision with car, skidded, fall, assault)
- **Place of occurrence** (School, home, road, at work)
- **Activity** (Sports, while working)

EXAMPLE :

Main diagnosis	Open fracture mid shaft of right humerus
Other diagnosis	Right ulnar nerve cut
Other diagnosis	Laceration wound at scalp
Other diagnosis (co-morbid)	Hypertension
Complication	N/A
External cause	Motorcycle rider in collision with car on highway on the way to work
Main procedure / surgery	Open reduction and internal fixation of right humerus
Other procedure	X-Ray right upper limb

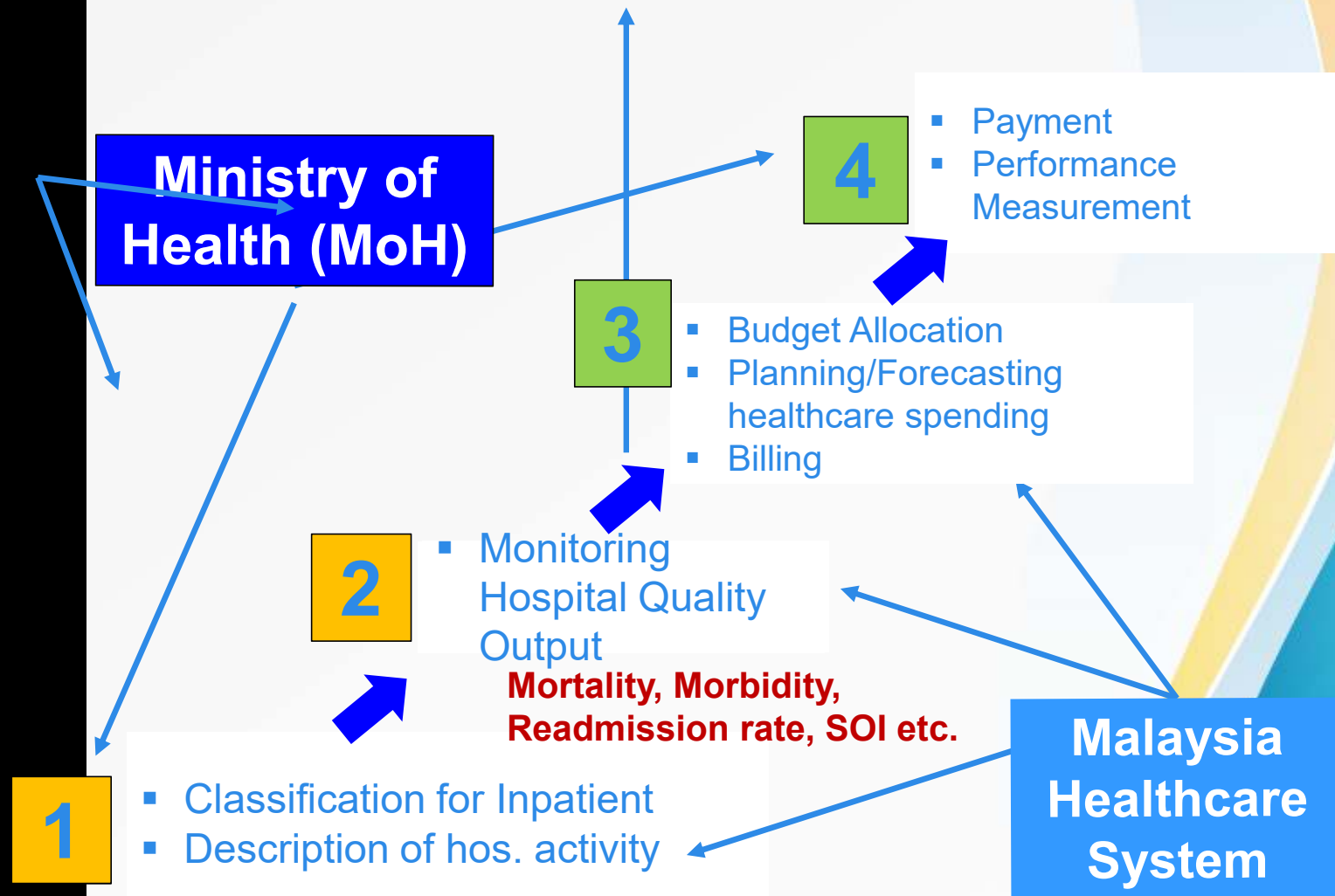
<p>27. DIAGNOSA (DIAGNOSIS) :</p> <p>I) DIAGNOSIS UTAMA <i>(Disease Or Condition Directly Leading To Death)</i> Closed intertrochanteric fracture of left femur</p>	<p>28. NOMBOR KOD</p> <p>i)</p>
<p>II) SEBAB-SEBAB KEMATIAN <i>(Cause Of Death)</i></p>	<p>ii)</p>
<p>III) SEBAB-SEBAB YANG MENYEBABKAN (UNDERLYING CAUSE) <i>(Disease or condition leading to death) DUE TO OR AS A CONSEQUENCES OF</i></p>	<p>iii)</p>
<p>IV) DIAGNOSIS LAIN (CO-MORBIDITY, jika ada) <i>(Antecedent causes giving rise to the above cause) DUE TO OR AS A CONSEQUENCES OF</i></p>	<p>iv)</p>
<p>v) DIAGNOSIS LAIN Hypertension</p>	<p>v)</p>
<p>VI) DIAGNOSIS KOMPLIKASI (jika ada)</p>	<p>vi)</p>
<p>VII) SEBAB-SEBAB LUARAN KECEDEeraan & KERACUNAN (External Causes Of Injury & Poisoning) Alleged fall on 27/7/19</p>	<p>vii)</p>
<p>VIII) FAKTOR-FAKTOR LAIN YANG MEMPENGARUHI TARAF KESIHATAN & KONTEK DENGAN PERKHIDMATAN KESIHATAN <i>(Antecedent causes giving rise to the above cause) DUE TO OR AS A CONSEQUENCES OF</i></p>	<p>viii)</p>

<p>27. DIAGNOSA (DIAGNOSIS) :</p> <p>I) DIAGNOSIS UTAMA <i>(Disease Or Condition Directly Leading To Death)</i> Closed fracture midshaft of left radius with DRUJ distraption</p>	<p>28. NOMBOR KOD</p> <p>i)</p>
<p>II) SEBAB-SEBAB KEMATIAN <i>(Cause Of Death)</i></p>	<p>II)</p>
<p>III) SEBAB-SEBAB YANG MENYEBABKAN (UNDERLYING CAUSE) <i>(Disease or condition leading to death) DUE TO OR AS A CONSEQUENCES OF</i></p>	<p>III)</p>
<p>IV) DIAGNOSIS LAIN (CO-MORBIDITY, jika ada) <i>(Antecedent causes giving rise to the above cause) DUE TO OR AS A CONSEQUENCES OF</i></p>	<p>IV)</p>
<p>V) DIAGNOSIS LAIN</p>	<p>V)</p>
<p>VI) DIAGNOSIS KOMPLIKASI (jika ada)</p>	<p>VI)</p>
<p>VII) SEBAB-SEBAB LUARAN KECEDEeraan & KERACUNAN (External Causes Of Injury & Poisoning) Alleged MVA on 19/7/19</p>	<p>VII)</p>
<p>VIII) FAKTOR-FAKTOR LAIN YANG MEMPENGARUHI TARAF KESIHATAN & KONTEK DENGAN PERKHIDMATAN KESIHATAN <i>(Antecedent causes giving rise to the above cause) DUE TO OR AS A CONSEQUENCES OF</i></p>	<p>VIII)</p>

<p>27. DIAGNOSA (DIAGNOSIS) :</p> <p>I) DIAGNOSIS UTAMA <i>(Disease Or Condition Directly Leading To Death)</i> Alleged MVA (MB Skidded, pillion rider)</p>	<p>28. NOMBOR KOD</p> <p>i)</p> <p>V89.29</p>
<p>II) SEBAB-SEBAB KEMATIAN <i>(Cause Of Death)</i></p>	<p>II)</p>
<p>III) SEBAB-SEBAB YANG MENYEBABKAN (UNDERLYING CAUSE) <i>(Disease or condition leading to death) DUE TO OR AS A CONSEQUENCES OF</i></p>	<p>III)</p>
<p>IV) DIAGNOSIS LAIN (CO-MORBIDITY, jika ada) <i>(Antecedent causes giving rise to the above cause) DUE TO OR AS A CONSEQUENCES OF</i></p>	<p>IV)</p>
<p>V) DIAGNOSIS LAIN</p> <p>TRO Pulmonary Tuberculosis</p>	<p>V)</p>
<p>VI) DIAGNOSIS KOMPLIKASI (jika ada)</p> <p>Left haemothorax Left pneumothorax Cerebral Concussion Splenic injury grade 3 Open communitated fracture proximal 3rd left humerus with radial nerve neuropraxia Right pneumothorax neurogenic bladder</p>	<p>VI)</p> <p>S27.10 S27.00 S06.00 S36.00 S42.21 S27.00 S37.20</p>



important milestones



IMPORTANT PARAMETERS TO BE MONITORED IN DRG PAYMENT

PARAMETERS	REASONS	EVIDENCE
❑ Average length of stay (ALOS)	Drop (15-24%) – 3 years <ul style="list-style-type: none"> ▪ Maximise profit 	<ul style="list-style-type: none"> ▪ Kahn et al. 1990 ▪ Samyshikin 1999
❑ Readmission rate	Rate : 5% to 29%, 15.8 (15.2–16.5)% <ul style="list-style-type: none"> ▪ Premature discharge ▪ To increase the volume 	<ul style="list-style-type: none"> ▪ Thomas and Holloway, 1991
❑ Volume of patient, especially SOI 1	Increase volume of unnecessary admission <ul style="list-style-type: none"> ▪ Maximise profit 	<ul style="list-style-type: none"> ▪ Hungary & Russia
❑ Upcoding – SOI (2 & 3)	“ Code Creep” <ul style="list-style-type: none"> ▪ Maximise profit 	<ul style="list-style-type: none"> ▪ Krit & Robinson 2013
❑ Cost per stay	Case-based payment systems for hospital funding in Asia: an investigation of current status and future directions. World Health Organization. 2015	

TOP 15 NATIONAL DIAGNOSIS-RELATED GROUP (DRG) WITH AVERAGE LENGTH OF STAY (ALOS), 2018

No	DRG code	DRG name	ALOS (days)
1.	14511	INTRAPARTUM AND POSTPARTUM CONDITIONS	2.8
2.	15561	NEONATE, BIRTHWEIGHT \geq 2000 GRAMS AFFECTED BY JAUNDICE	2.7
3.	14501	ANTEPARTUM CONDITIONS	3.0
4.	04501	PNEUMONIA	4.2
5.	04531	BRONCHITIS & ASTHMA	3.2
6.	14001	CAESAREAN SECTION	4.7
7.	03501	EAR, NOSE, MOUTH & THROAT INFECTIONS	3.0
8.	06561	ESOPHAGITIS, GASTROENTERITIS & MISCELLANEOUS DIGESTIVE DISORDERS	2.9
9.	15551	NEONATE, BIRTHWEIGHT \geq 2000 GRAMS AFFECTED BY RESPIRATORY, CARDIOVASCULAR CONDITIONS OR INFECTIONS	4.0
10.	14011	OTHER OPERATIVE OBSTETRICS PROCEDURES	2.7
11.	18511	DENGUE	3.9
12.	23521	OTHER FACTORS INFLUENCING HEALTH STATUS	2.9
13.	05532	CORONARY ARTERY DISEASE	4.1
14.	14512	INTRAPARTUM AND POSTPARTUM CONDITIONS	3.4
15.	06571	OTHER GASTROINTESTINAL SYSTEM DISORDERS & INFECTIONS	3.3

Source: EIS, Casemix MoH

Inclusion Criteria: Home, Inpatient, Closed Case


 Approved by:
 Dr Mohd Ridwan Shahari,
 Senior Principal Assistant Director,
 Public Health Physician,
 Head of Casemix Subunit
 6th January 2021


TOP 15 NATIONAL 30-DAYS READMISSION RATE BASED ON ICD-10, 2018

NO	ICD-10 CODE	ICD-10 Description	Rate (%)
1.	P59.9	NEONATAL JAUNDICE, UNSPECIFIED	8.3
2.	J44.1	CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH ACUTE EXACERBATION, UNSPECIFIED	10.3
3.	I20.0	UNSTABLE ANGINA	4.7
4.	I50.0	CONGESTIVE HEART FAILURE	5.0
5.	E87.7	FLUID OVERLOAD	7.8
6.	J18.9	PNEUMONIA, UNSPECIFIED	1.6
7.	J45.9	ASTHMA, UNSPECIFIED	2.2
8.	O99.0	ANAEMIA COMPLICATING PREGNANCY, CHILDBIRTH AND THE PUERPERIUM	3.7
9.	D64.9	ANAEMIA, UNSPECIFIED	2.7
10.	G40.9	EPILEPSY, UNSPECIFIED	3.9
11.	J18.0	BRONCHOPNEUMONIA, UNSPECIFIED	1.4
12.	E14.5	UNSPECIFIED DIABETES MELLITUS: WITH PERIPHERAL CIRCULATORY COMPLICATIONS	7.6
13.	O13	GESTATIONAL (PREGNANCY-INDUCED) HYPERTENSION WITHOUT SIGNIFICANT PROTEINURIA	7.8
14.	O24.4	DIABETES MELLITUS ARISING IN PREGNANCY	1.6
15.	J21.9	ACUTE BRONCHIOLITIS, UNSPECIFIED	2.1

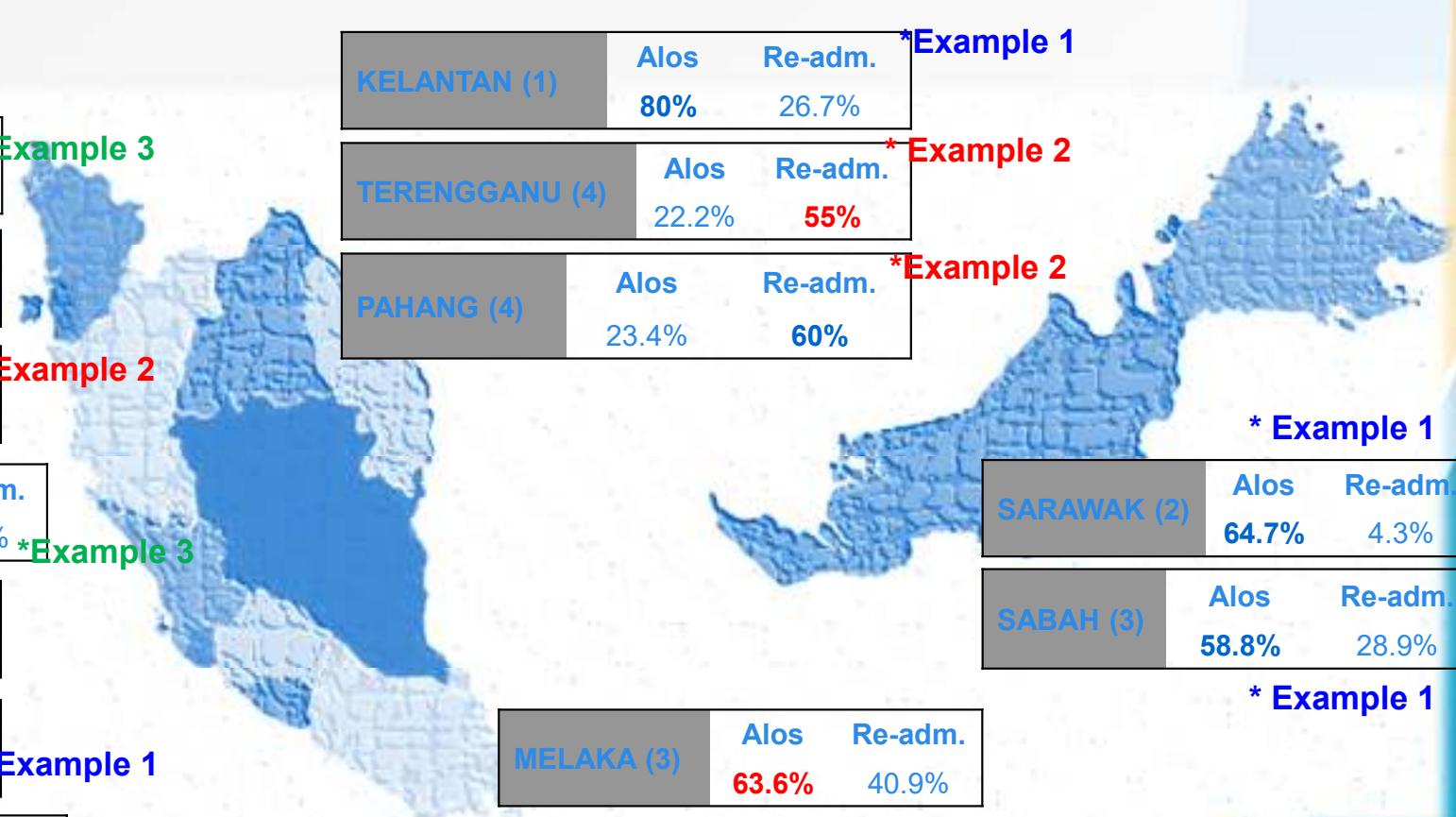
Source: EIS, Casemix MoH

Inclusion Criteria: Home, Inpatient, Closed, Main Condition ICD-10

After excluding malignancy, renal failure & renal related problem and psychiatric disorder

Approved by: 
 Dr Mohd Ridwan Shahari,
 Senior Principal Assistant Director,
 Public Health Physician,
 Head of Casemix Subunit
 6th January 2021

%- Alos & Readmission Rate by State > National Rate - 2018



PERLIS (1)	Alos	Re-adm.
	73.3%	40%

KELANTAN (1)	Alos	Re-adm.
	80%	26.7%

*Example 1

KEDAH (3)	Alos	Re-adm.
	16.7%	35.5%

*Example 3

TERENGGANU (4)	Alos	Re-adm.
	22.2%	55%

*Example 2

P.PINANG (5)	Alos	Re-adm.
	37.7%	45.3%

PAHANG (4)	Alos	Re-adm.
	23.4%	60%

*Example 2

PERAK (10)	Alos	Re-adm.
	29.8%	50%

*Example 2

SELANGOR (6)	Alos	Re-adm.
	41.4%	16.6%

*Example 3

SARAWAK (2)	Alos	Re-adm.
	64.7%	4.3%

* Example 1

IKN	Alos	Re-adm.
	0%	33.3%

SABAH (3)	Alos	Re-adm.
	58.8%	28.9%

* Example 1

HKL	Alos	Re-adm.
	73.3%	40%

*Example 1

MELAKA (3)	Alos	Re-adm.
	63.6%	40.9%

N. SEMBILAN (5)	Alos	Re-adm.
	34.9%	40%

*Example 3

JOHOR (1)	Alos	Re-adm.
	33.3%	13.3%

*Example 3



STATE: KEDAH

TOP 15 NATIONAL DRG WITH HOSPITAL AVERAGE LENGTH OF STAY (DAYS), 2018 (35.5%)

TOP 15 CASES	1	2	3	4	5	6	7	8	9
DRG CODE	14511	15561	14501	04501	04531	14001	03501	06561	15551
	2.5	2.5	3.1	4.3	3.4	4.5	3.3	3.0	3.7
	2.3	2.4	2.8	3.6	2.9	-	2.8	2.8	-
	2.3	2.6	2.9	3.5	3.0	-	2.7	2.6	-

TOP 15 NATIONAL 30-DAYS READMISSION RATE (%) BASED ON ICD-10, 2018 (35.5%)

TOP 15 CASES	1	2	3	4	5	6	7	8	9
ICD-10	P59.9	J44.1	I20.0	I50.0	E87.7	J18.9	J45.9	O99.0	D64.9
	12.3	9.2	3.3	3.0	8.4	1.4	2.8	1.3	3.4
	5.8	16.6	1.1	1.3	4.2	1.7	2.7	14.3	0.0
	5.3	13.2	0.0	1.5	9.7	1.5	2.2	0.0	2.1



**KERAJAAN MALAYSIA
WARAN PERUNTUKAN**

(Kew.308F-In.1/2016)

Belanjawan bagi Tahun 2017 & 2018

Jenis Urusniaga	Pejabat Perakaunan	No. Dokumen	Tarikh Dokumen
F28	1107	91003412	17.03.2021
Kod Pegawai Pengawal Menguat	D4	KETUA SETIAUSAHA KEMENTERIAN KESIHATAN	
Perihal Kumpulan PTJ Pengeluar	Jabatan Kesihatan Negeri Kedah		
Perihal	Peruntukan bagi rawatan pesakit bagi hospital Kementerian Kesihatan Malaysia		

- Tuan adalah diberi kuasa melakukan perbelanjaan dibawah dalam tempoh 01 Januari 2017/2018 hingga Disember 2017/2018. Untuk berbuat demikian waran ini bersama dengan Bil Perakuan dan Penyelesaian yang sempurna adalah mencukupi untuk melepaskan tanggungjawab ini.
- Perbelanjaan yang melebihi peruntukan adalah tidak dibenarkan melainkan jika ada peruntukan tambahan yang diberi kepada tuan melalui waran peruntukan yang selanjutnya.

PERUNTUKAN DIMASUKAN KIRA KEPADA AKAUN-AKAUN DIBAWAH

KOD PENERIMA

Tahun	Pegawai Pengawal	Kumpulan PTJ & PTJ	Program Aktiviti	Amaun (RM)	
				Line-Item	DRG
2017	D4	42030161	030000	T/B	T/B
2018	D4	42030161	030000	34,142,030.70	32,045,623.41

REST...

- COMPLETE MORTALITY
- THANK U ...*FOR PROPER DOCUMENTATION AND CODING*

THANK YOU

DO'S & DON'T'S IN DOCUMENTING DIAGNOSIS

DO'S

- Proper documentation of Main Diagnosis
- Legible handwriting
- To document all other conditions relevant heading of Other Diagnosis
- Document procedures in the Procedure Column

DONT'S

- Do not use abbreviations
- Do not write procedures as Main Diagnosis



What procedures **NOT** to document...???

Non-operative procedures :

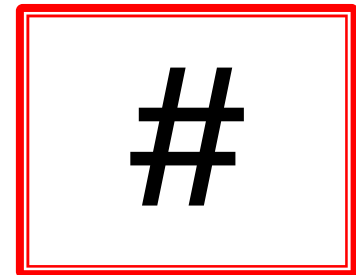
- **Nursing routine procedures which –**
 - Do not required specialized staff
 - Do not required special equipment

Example : dressing, vital signs, sponging, I/O Charting, GCS Charting

- **Setting up peripheral arterial and venous line**
- **All blood investigations except **Blood C&S****

CHALLENGES & ERRORS INVOLVING MAJORITY OF DEPARTMENTS

- Incomplete PD301 (**No main diagnosis / comorbidities**)
- Wrong placement
- Codes without diagnosis
- Repeated diagnosis
- Abbreviation / Acronyms
- Illegible handwriting
- Unrecognized / Unfamiliar symbols
- Multiple diagnoses in a row
- Procedure as diagnosis



BORANG DAFTAR MASUK DAN KELUAR HOSPITAL

PER-PO 301
(Rev. 2/2008)

1. NAMA (JULUK/BEKAS) : ASYAH BATRISYA BINTI MUHAMAD AL- ARIF		2. NO. APL PERUMPTARAN : 3690271646 (247020)	
3. NAMA LAIN (jika ada) :		3. ARAH PULAU : INL TIDAK	
4. ALAMAT (SEHINGGA) : MUKIM APAM LUBUK JONG, PASIR MAS, KELANTAN		5. NOMBOR PENGESAHAN BAHU :	
6. NO. TELEFON : 0139723023		7. JANTINA : FEMALE	8. TARICAH LAHIR : 02/01/2018
9. UMUR : 1 YR 8 MTHS 1 DAY		10. SEX : M	
11. STATUS PERKAHWINAN : BELUM BERKAHWIN	12. AGAMA : ISLAM	13. NAMA BAHAGIAN/UNIT : uzb	
14. PENDAPATAN : 0.00kg		15. ALAMAT :	
16. PERALIHAN : EXT. REFERRAL - GOVERNMENT HOSPITAL		17. NOMBOR PERALIHAN :	
18. STATUS : DISCHARGE I		19. NOMBOR PERALIHAN :	
21. TURUN :	22. TURUN :	23. TURUN :	24. TURUN :
25. TURUN :	26. TURUN :	27. TURUN :	28. TURUN :
29. JAWABAN PELAKSANA : I. Di Hospital Rawatan : <input type="checkbox"/> II. Di Rumah : <input type="checkbox"/>			
30. DIAGNOSA (DIAGNOSIS) :			
I) DIAGNOSIS UTAMA <i>(Disease Or Condition Directly Leading To Death)</i> 1)viral fever with parentral diarrhea 2)cover for leptospirosis 3)nosocomial pneumonia4)new onset of dystonia 5)increase in frequency of fitting episode 6)Feeding intolerance 7)mild laryngomalacia			
II) SEBAB-SEBAB KEMATIAN <i>(Cause Of Death)</i>			
III) SEBAB-SEBAB YANG MENYEBABKAN (UNDERLYING CAUSE) <i>(Disease or condition leading to death) DUE TO OR AS A CONSEQUENCES OF</i>			
IV) DIAGNOSIS LAIN (CO-MORBIDITY, jika ada) <i>(Antecedent causes giving rise to the above cause) DUE TO OR AS A CONSEQUENCES OF</i> 1)Semilobar holoprosencephaly with epilepsy 2)Diabetes Insipidus 3)GDD 4)microcephaly with closes suture TRO craniosynostosis			
31. DIAGNOSIS KOMPLIKASI (jika ada) :			
32. JAWABAN SEBAB KEMATIAN KECERDASAN BAKAL & PENYALAMAN (Disease/Cause Of Injury & Poisoning) :			

27. DIAGNOSA (DIAGNOSIS) :

I) DIAGNOSIS UTAMA

(Disease Or Condition Directly Leading To Death)

1)viral fever with parentral diarrhea 2)cover for leptospirosis 3)nosocomial pneumonia4)new onset of dystonia 5)increase in frequency of fitting episode 6)Feeding intolerance 7)mild laryngomalacia

II) SEBAB-SEBAB KEMATIAN

(Cause Of Death)

III) SEBAB-SEBAB YANG MENYEBABKAN (UNDERLYING CAUSE)

(Disease or condition leading to death) DUE TO OR AS A CONSEQUENCES OF

IV) DIAGNOSIS LAIN (CO-MORBIDITY, jika ada)

(Antecedent causes giving rise to the above cause) DUE TO OR AS A CONSEQUENCES OF

1)Semilobar holoprosencephaly with epilepsy 2)Diabetes Insipidus 3)GDD 4)microcephaly with closes suture TRO craniosynostosis

BORANG DAFTAR MASUK DAN KELUAR HOSPITAL

PER-PD 301
(Fin. 2/2009)

1. NAMA (HURUF BESAR) : MUHAMAD DANISH HAFIZ BIN ZULKIFLI NAMA LAIN (jika ada) :		2. NO. SIRI PENDAFTARAN : HRPZ550341 (2632451)	
4. ALAMAT SEKARANG : NO 773 KG KOR, JALAN KUALA KRAI, 16010 KOTA BHARU, KELANTAN		3. KES POLIS : YA <input type="checkbox"/> TIDAK <input type="checkbox"/>	
		5. I) NO KAD PENGENALAN BARU : 151119031217 E) LAIN-LAIN PENGENALAN :	
6. NO. TELEFON : 0109056656	7. JANTINA : MALE	8. TARIKH LAHIR : 19/11/2015	9. UMUR : 3 YRS 9 MTHS 15 DAYS
15. TARAF PERKAHWINAN : BELUM BERKAHWIN		10. WARGANEGARA (Nyatakan -) MALAYSIA(MELAYU)	
12. AGAMA : ISLAM		15. NAMA SALDARA / WARS : unknown	
13. PEKERJAAN : OTHERS		16. ALAMAT :	
14. BERAT BADAN (bagi bayi <= 30 hari dalam gram) 0.00kg		17. HUBUNGAN KEKELUARGAAN :	
18. PUNCA RUJUKAN : EXT. REFERRAL - GOVERNMENT HOSPITAL		20. DISCAJ : TRANSFER	
21. TARIKH : 15/01/2019	KEMASUKAN	PINDAH I	PINDAH II
22. WAKTU : 19:02			
23. WAD : WARD 4			
24. KELAS : THIRD CLASS			
25. DISPLIN : PENSIPTER 44			

27. DIAGNOSA (DIAGNOSIS) :

I) **DIAGNOSIS UTAMA**

(Disease Or Condition Directly Leading To Death)

Transfer to HUSm as planned

27. DIAGNOSA (DIAGNOSIS) :	28. NUMBER ICD
I) DIAGNOSIS UTAMA <i>(Disease Or Condition Directly Leading To Death)</i> Transfer to HUSm as planned	I)
II) SEBAB-SEBAB KEMATIAN <i>(Cause Of Death)</i>	II)
III) SEBAB-SEBAB YANG MENYEBABKAN (UNDERLYING CAUSE) <i>(Disease or condition leading to death) DUE TO OR AS A CONSEQUENCES OF</i>	III)
IV) DIAGNOSIS LAIN (CO-MORBIDITY) , (jika ada) <i>(Antecedent causes giving rise to the above cause) DUE TO OR AS A CONSEQUENCES OF</i>	IV)
V) DIAGNOSIS LAIN Failure to thrive with hepatosplenomegaly Sweet syndrome	V)
VI) DIAGNOSIS KOMPLIKASI (jika ada)	VI)

BORANG DAFTAR MASUK DAN KELUAR HOSPITAL

PER-PD 301
(Pn. 2/2009)

1. NAMA (HURUF BESAR) : NIK AMINAH BINTI ABDULLAH NAMA LAIN (jika ada) :		2. NO. SRI PENDAFTARAN : HRP2364565 (2673781)	
4. ALAMAT SEKARANG : PT 884 TAMAN NASHRIQ, KG SENOK, 16300 BACHOK, KELANTAN		3. KES POLIS : YA <input type="checkbox"/> TIDAK <input type="checkbox"/>	
		5. I) NO KAD PENGENALAN BARU : 820321035444 II) LAIN-LAIN PENGENALAN :	

6. NO. TELEFON : 012-8878706	7. JANTINA : FEMALE	8. TARBIH LAHIR : 21/03/1982	9. UJULI : 37 YRS	10. WARGANEGARA (Nyatakan -) : MALAYSIA(MELAYU
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11. TARAF PERKAHWINAN : BERKAHWIN	12. AGAMA : ISLAM	15. NAMA SAUDARA / WARS : unknown
	13. PEKERJAAN : OTHERS	16. ALAMAT :
	14. BERAT BADAN (bagi bayi <= 30 hari dalam gram) : 0.00kg	17. HUBUNGAN KEKELUARGAAN :

18. PUNCA Rujukkan : EXT. REFERRAL - GOVERNMENT HOSPITAL	20. DISCAJ : DISCHARGE HOME
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	KEMASUKAN	PINDAH I	PINDAH II	PINDAH III	
21. TARIKH :	5/02/2018				
22. WAKTU :	09:00				
23. WAD :	WARD 80808A				
24. KELAS :	THIRD CLASS				
25. DISPLIN :	GENERALIST				TRIP

26. JANGKAMASA PESAKIT :	
I. Di bawah Rawatan	Ya
B. Dalam Ventilator	Tidak

27. DIAGNOSA (DIAGNOSIS)	28. MONITOR HCD
I) DIAGNOSIS UTAMA (Disease Or Condition Directly Leading To Death) SUCTION AND EVACUATION	I)
II) SEBAB-SEBAB KEMATIAN (Cause Of Death)	II)
III) SEBAB-SEBAB YANG MENYEBABKAN (UNDERLYING CAUSE) (Disease or condition leading to death) DUE TO OR AS A CONSEQUENCES OF	III)
IV) DIAGNOSIS LAIN (CO-MORBIDITY, jika ada) (Antecedent causes giving rise to the above cause) DUE TO OR AS A CONSEQUENCES OF	IV)
V) DIAGNOSIS LAIN	V)
VI) DIAGNOSIS KOMPLIKASI (jika ada)	VI)

27. DIAGNOSA (DIAGNOSIS) :

I)

DIAGNOSIS UTAMA

(Disease Or Condition Directly Leading To Death)

SUCTION AND EVACUATION



BORANG DAFTAR MASUK DAN KELUAR HOSPITAL

PER-PD 301
(Pn. 2/2009)

1. NAMA (HURUF BESAR) : ABDULLAH BIN MUHAMAD NAMA LAIN (jika ada) :		2. NO. SIRI PENDAFTARAN : HRP2332746 (2375473)
4. ALAMAT SEKARANG : 328 LORONG TITIAN DATO,, KM 5 JLN SULTAN YAHYA PETRA, 15200 KOTA BHARU, KELANTAN		3. KES POLIS : YA TIDAK
		5. I) NO KAD PENGENALAN BARU : 340717036085 II) LAIN-LAIN PENGENALAN :

6. NO TELEFON : 0126268813	7. JANTINA : MALE	8. TARIKH LAHIR : 17/07/1934	9. UMUR : 85 YRS	10. WARGANEGARA (Nyata) : MALAYSIA(MEI)
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11. TARAF PERKAHWINAN : BERKAHWIN	12. AGAMA : ISLAM	15. NAMA SAUDARA / WARS : unknown
	13. PEKERJAAN : OTHERS	16. ALAMAT :
	14. BERAT BADAN (bagi bayi <= 30 hari dalam gram) 0.00kg	17. HUBUNGAN KEKELUARGAAN :

18. PUNCA Rujukan : EXT. REFERRAL - GOVERNMENT HOSPITAL	20. DISCAJ : DISCHARGE HOME
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	KEMASUKAN	PINDAH I	PINDAH II	PINDAH III
21. TARIKH :	08/07/2018			
22. WAKTU :	12.50			
23. WAD :	WAD 16			
24. KELAS :	ONE BEDDED ROOM			
25. DISTRUK :	PERUBATAN AM			

26. JANGKAPAN PERSEKIT	
L. Di bawah Elevator	Yes
B. Dalam Ventilator	Yes

27. DIAGNOSA (DIAGNOSIS)	28. NUMBER ICD
I) DIAGNOSIS UTAMA (Disease Or Condition Directly Leading To Death) MPD	6
II) SEBAB-SEBAB KEAMATAN (Cause of Death)	61
III) SEBAB-SEBAB YANG MENYEBABKAN (UNDERLYING CAUSE) (Disease or condition leading to death) DUE TO OR AS A CONSEQUENCES OF	60
IV) DIAGNOSIS LAIN (CO-MORBIDITY, jika ada) (Antecedent causes giving rise to the above cause) DUE TO OR AS A CONSEQUENCES OF	6V
V) DIAGNOSIS LAIN	6V

27. DIAGNOSA (DIAGNOSIS) :

I) DIAGNOSIS UTAMA

(Disease Or Condition Directly Leading To Death)

MPD

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(Rev. 2/2009)

1. NAMA (HURUF BESAR) : KAMARUZAMAN BIN ALI		2. NO. DIRI PENDAFTARAN : HRPZ551232 (2189813)	
NAMA LAIN (jika ada) :		3. KES POLIS : YA / TIDAK	
4. ALAMAT SEKARANG : 3342, JALAN SULTANAH ZAINAB, 15050 KOTA BHARU, KELANTAN		5. (i) NO KAD PENGENALAN BARU : 590825035527	
		6) LAIN-LAIN PENGENALAN :	

6. NO. TELEFON : 0179229181	7. JANTINA : MALE	8. TARBIH LAHIR : 25/08/1959	9. UMUR : 60 YRS	10. WARIS : MAI
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11. TARAF PERKAHWINAN : BERKAHWIN	12. AGAMA : ISLAM	15. NAMA SAUDARA / WARS : unknr
	13. PEKERJAAN : OTHERS	
	14. BERAT BADAN (bagi bayi <= 30 hari dalam gram) 0.00kg	
16. ALAMAT :		17. HUBUNGAN KEKELUARGAAN :

18. PUNCA RUJUKAN : EXT. REFERRAL - GOVERNMENT HOSPITAL	20. DISCAJ : DISCHARGE HC
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	KEMASUKAN	PINDAH I	PINDAH II	PINDAH III
21. TARBIH :	1402/2019			
22. WAKTU :	22:00			
23. WAD :	WAD MELATI			
24. KELAS :	THIRD CLASS			
25. DISPLIN :	DFT (A/MS/08)			

26. JANGKAJASA PESAKIT :	
I. Di bawah Rawatan :	140
II. Di luar Ventilator :	140

27. DIAGNOSA (DIAGNOSIS) :	28. NOMBOR BOD :
I) DIAGNOSIS UTAMA (Disease Or Condition Directly Leading To Death) pod6 re tppv/el/me/phaco/pciol	I)
II) SEBAB-SEBAB KEMATIAN (Cause Of Death)	II)
III) SEBAB-SEBAB YANG MENYEBABKAN (UNDERLYING CAUSE) (Disease or condition leading to death) DUE TO OR AS A CONSEQUENCES OF	III)
IV) DIAGNOSIS LAIN (CO-MORBIDITY, jika ada) (Antecedent disease giving rise to the above cause) DUE TO OR AS A CONSEQUENCES OF	IV)
V) DIAGNOSIS LAIN re hyphaema 2ry to heparinization	V)
VI) DIAGNOSIS KOMPLIKASI (jika ada)	VI)

27. DIAGNOSA (DIAGNOSIS) :

I)

DIAGNOSIS UTAMA

(Disease Or Condition Directly Leading To Death)

pod6 re tppv/el/me/phaco/pciol



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1. NAMA (HURUF BESAR) : NUR AZWANI BINTI MOHAMAD		2. NO. SRI PENDAFTARAN : HRPZ298289 (2399100)	
NAMA LAIN (jika ada) :		3. KES POLIS : YA TIDAK	
4. ALAMAT SEKARANG : 5050 KG SIREH, BAWAH LEMBAH, 15050 KOTA BHARU, KELANTAN		5. (I) NO KAD PENGENALAN BARU : 880410035088	
		6) LAJUAN PENGENALAN :	

4. NO. TELEFON : 0129673776	7. JANTINA : FEMALE	8. TARBIH LAHIR : 10/04/1988	9. UMUR : 31 YRS	10. WARGANEGARA (Nyatakan -) : MALAYSIA(MELAYU)
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11. TARAF PERKAHWINAN : BERKAHWIN	12. AGAMA : ISLAM	15. NAMA SALIDARA / WARS : unknown	
	13. PEKERJAAN : OTHERS		16. ALAMAT :
	14. BERAT BADAN (bagi bayi <= 30 hari dalam gram) : 0.00kg		17. HUBUNGAN KEKELUARGAAN : ...

18. PUNCA Rujukan : EXT. REFERRAL - GOVERNMENT HOSPITAL	20. DISCAI : DISCHARGE HOME
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	KEMERLOKAN	DRUKAN I	DRUKAN II	DRUKAN III
21. TARIKH :	14/02/2018			
22. WAKTU :	18:00			
23. WAD :	WARD 39			
24. KELAS :	THIRD CLASS			
25. DISPLIN :	OBSTETRIK			082

26. JANGKAMASA PESAKIT	
I. Di bawah Rawatan	Yes
II. Dalam Ventilator	Yes

27. DIAGNOSA (DIAGNOSIS)	28. NOMBOR HOSP
I) DIAGNOSIS UTAMA (Disease Or Condition Directly Leading To Death) REASSURANCE	I)
II) SEBAB-SEBAB KEMATIAN (Cause Of Death)	II)
III) SEBAB-SEBAB YANG MENYEBABKAN (UNDERLYING CAUSE) (Disease or condition leading to death) DUE TO OR AS A CONSEQUENCES OF	III)
IV) DIAGNOSIS LAIN (CO-MORBIDITY) (jika ada) (Antecedent causes giving rise to the above cause) DUE TO OR AS A CONSEQUENCES OF	IV)
V) DIAGNOSIS LAIN	V)
VI) DIAGNOSIS KOMPLIKASI (jika ada)	VI)

27. DIAGNOSA (DIAGNOSIS) :

I) DIAGNOSIS UTAMA
(Disease Or Condition Directly Leading To Death)
REASSURANCE



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1. NAMA (HURUF BESAR) : SITI HAJAR BINTI MOHD KHAIRUL IRWAN NAMA LAIN (jika ada) :		2. NO. SRI-PENDAFTARAN : HRP2749929 (2420637)	
4. ALAMAT SEKARANG : LOT 105A KAMPUNG KUALA BESAR, BADANG, 15350 KOTA BHARU, KELANTAN		3. KES POLIS : YA TIDAK	
		5. (I) NO KAD PENGENALAN BARU : 180701031098 (I) LAIN-LAIN PENGENALAN :	
6. NO. TELEFON : 013 9182582	7. JANTINA : FEMALE	8. TARikh LAHIR : 01/07/2018	9. UMUR : 1 YR 2 MTHS 2 DAYS
		10. WARGANEGARA (Nyatakan -) : MALAYSIA(MELAYU)	

11. TARAF PERKAHWINAN : BELUM BERKAHWIN	12. AGAMA : ISLAM	15. NAMA SALUDARA / WARS : unknown	
	13. PEKERJAAN : OTHERS		16. ALAMAT :
	14. BERAT BADAN (bagi bayi <= 30 hari dalam gram) : 0.00kg		17. HUBUNGAN KEKELUARGAAN :

18. PUNCA Rujukan : EXT. REFERRAL - GOVERNMENT HOSPITAL	20. DISCAI : DISCHARGE HOME
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	KEMASUKAN	PINDAH I	PINDAH II	PINDAH III
21. TARikh :	18062018			
22. WAKTU :	12-12			
23. WAD :	WAD 5			
24. KELAS :	THIRD CLASS			
25. DISPLIN :	PERUGATAN PEDIATRIK			

26. JAWABANADA PESIVIT :	
I. Di bawah Rasteris :	180
II. Dalam Ventilasi :	180

27. DIAGNOSA (DIAGNOSIS) :	
I) DIAGNOSIS UTAMA (Disease Or Condition Directly Leading To Death) possibly cow	
II) SEBAB-SEBAB KETUMBUHAN (Cause Of Death)	+
III) SEBAB-SEBAB YANG MENYEBABKAN (UNDERLYING CAUSE) (Disease or condition leading to death) DUE TO OR AS A CONSEQUENCES OF	0
IV) DIAGNOSIS LAIN (CO-MORBIDITY, jika ada) (Antecedent causes giving rise to the above cause) DUE TO OR AS A CONSEQUENCES OF	0
V) DIAGNOSIS LAIN :	0
VI) DIAGNOSIS KOMPLIKASI (jika ada)	0
VII) SEBAB-SEBAB LUARAN KECEDERAAN & KERACUNAN (External Causes Of Injury & Poisoning)	0

27. DIAGNOSA (DIAGNOSIS) :

I) DIAGNOSIS UTAMA
(Disease Or Condition Directly Leading To Death)
possibly cow



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1. NAMA (HURUF BESAR) : NIK KHADIJAH BINTI NIK HUSAIN NAMA LAIN (jika ada) :		2. NO. SIRI PENDAFTARAN : HRP2728269 (2268577)	
4. ALAMAT SEKARANG : KG PADANG MO'KAN, PERINGAT, 16400 MELOR, KELANTAN		3. RES POLIS : YA TIDAK	
5. (1) NO KAD PENGENALAN BARU : 420122035190		6. (2) LAINLAIN PENGENALAN :	
8. NO. TELEFON : 0129293374	7. JANTINA : FEMALE	9. TARBIH LAHIR : 22/01/1942	10. UMUR : 77 YRS
11. TARAF PERAWATAN : TIADA MAKLUMAT		12. AGAMA : ISLAM	
13. PEKERJAAN : OTHERS		15. NAMA SAUDARA / WARS : unknown	
14. BERAT BADAN (bagi bayi <= 30 hari dalam gram) : 0.00kg		16. ALAMAT :	
18. PUNCA RALUJUKAN : EXT. REFERRAL - GOVERNMENT HOSPITAL		20. DISCAJ : DISCHARGE HOME	

27. DIAGNOSA (DIAGNOSIS) :

I) **DIAGNOSIS UTAMA**
(Disease Or Condition Directly Leading To Death)
591111035466

21. TARIKH :	SEMADURAN	PERINGAT	PERINGAT	PERINGAT
22. WAKTU :	12:00:00	12:00:00	12:00:00	12:00:00
23. WAD :	WAD PUTERI	WAD DARUL	WAD DARUL	WAD DARUL
24. KELAS :	TRIMU CLAS	TRIMU CLAS	TRIMU CLAS	TRIMU CLAS
25. DISIPUL :	PERUBATAN	PERUBATAN	PERUBATAN	PERUBATAN
26. JANGKAMASA PESAKIT				
i. Di bawah Rawatan				
ii. Dalam Ventilator				
27. DIAGNOSA (DIAGNOSIS)				
I) DIAGNOSIS UTAMA (Disease Or Condition Directly Leading To Death) 591111035466				II
II) SEBAB-SEBAB KEMATIAN (Cause Of Death)				III
III) SEBAB-SEBAB YANG BERTYERUSUJAN LANGSUNG KE KEMATIAN (Disease or condition leading to death DUE TO OR AS A CONSEQUENCE OF)				IV
IV) DIAGNOSIS LAIN (COMORBIDITI) (jika ada) (Accidental cause giving rise to the above causes DUE TO OR AS A CONSEQUENCE OF)				V
V) DIAGNOSIS LAIN				VI
VI) DIAGNOSIS KOMPLIKASI (jika ada)				VII



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29. PEMBEDAHAN / PROSEDUR (jika ada) :

**BLOOD TAKING
I/O CHARTING**

30. JENIS PEMBEDAHAN

31. KELAS

32. NOMBOR KOD

33. NAMA PEGAWAI PERUBATAN :

34. TANDATANGAN, TARIKH & COP JAWATAN :

35. NAMA PAKAR YANG MERAWAT :

36. TANDATANGAN, TARIKH & COP JAWATAN :

37. CATATAN :

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29. PEMBEDAHAN / PROSEDUR (jika ada) :

PT IS REVIEWED

30. JENIS PEMBEDAHAN

31. KELAS

32. NOMBOR KOD

34. TANDATANGAN, TARIKH

35. NAMA PAKAR YANG MERAWAT :

(MMC : 0)

36. TANDATANGAN, TARIKH & COP JAWATAN :

37. CATATAN :

PEGAWAI PERUBATAN
WAD MELATI
Hospital Raja Perempuan Zainab
KOTA BHARU, KELANTAN

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9. PEMBEDAHAN / PROSEDUR (jika ada) :

- 1. DISCHARGE WITH ORAL ACYCLOVIR (TOTAL 10/7)- ANOTHER 5 DAYS
- 2. MDI SALBUTAMOL 4H X2/7 , THEN 6H X2/7, THEN PRN BASIS.
- 3. ADVICE OF NOT TO SEND PT TO NURSERY YET, UNTIL THE LESION FULLY RESOLVE

30. JENIS PEMBEDAHAN

31. KELAS

32. NOMBOR KOD

33. NAMA PEGAWAI PERUBATAN :



34. TANDATANGAN, TARIKH & COP JAWATAN :

35. NAMA PAKAR YANG MERAWAT :

(MMC : 0)

36. TANDATANGAN, TARIKH & COP JAWATAN :

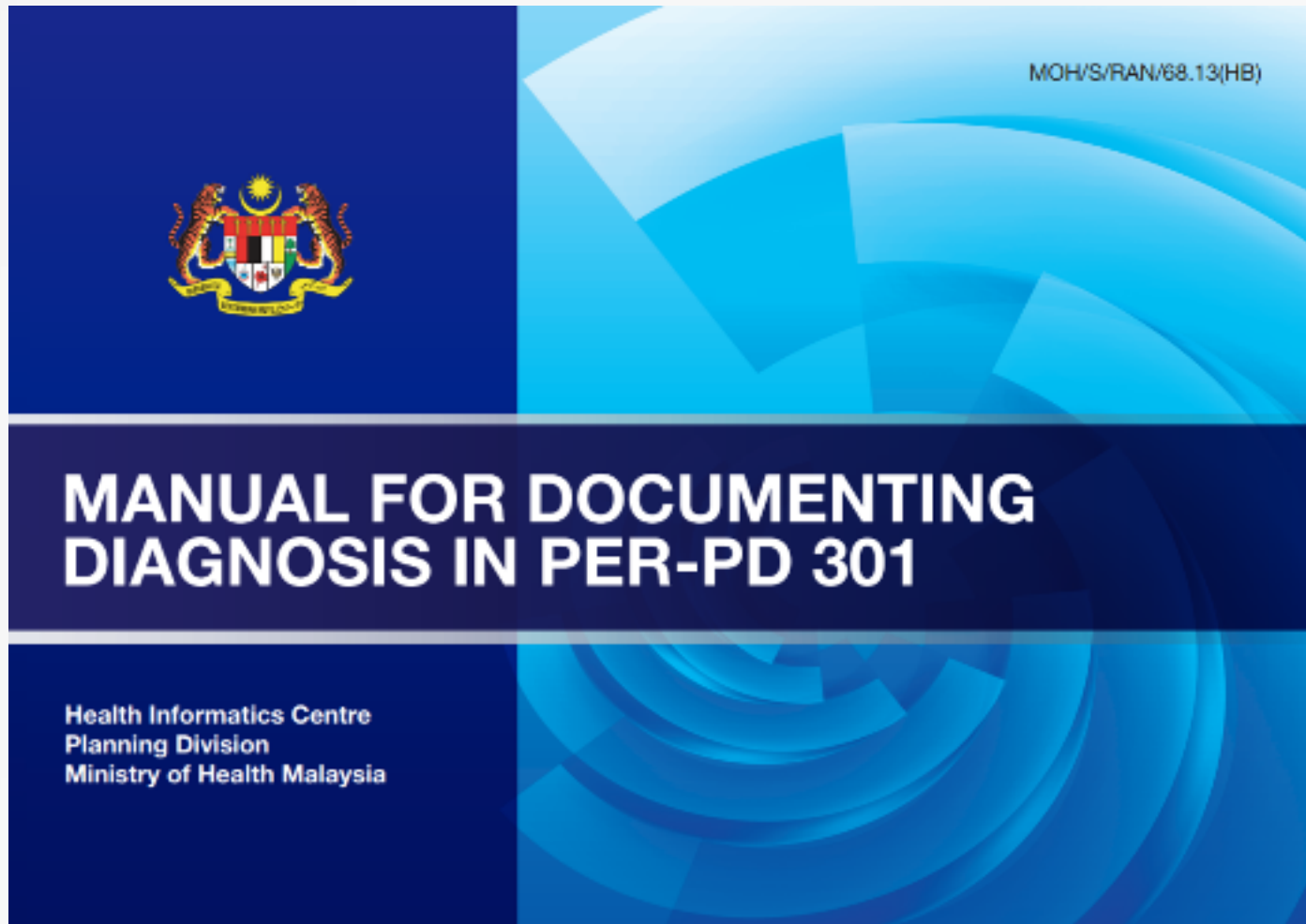
37. CATATAN :

TAKE HOME MESSAGE...

Please make sure :

- ✓ Main Diagnosis and Other Diagnosis are documented
- ✓ Co-morbidities/ Underlying diseases are documented
- ✓ Main Procedure and Other Procedures are documented
- ✓ All procedure(s) executed by ALL other allied health personnel be recorded
- ✓ PD301 signed and stamped by discharging doctor (HO) and verified by MO/SP

REFERENCE



THANK YOU