PEJABAT TIMBALAN KETUA PENGARAH KESIHATAN(PERUBATAN)
KEMENTERIAN KESIHATAN MALAYSIA
ARAS 2-7, BLOK E1, PARCEL E, PRESINT 1,
PUSAT PENTADBIRAN KERAJAAN PERSEKUTUAN
62590, PUTRAJAYA

TEL NO : 03-88831400
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Ruj. Kami : KKM/87/P1/9/6/2 (12)
Tarikh : 9 Disember 2014

SENARAI SEPERTI EDARAN

YBhg Datuk/Dato'/Datin/Tuan/Puan,

PENGGUNAAN BORANG *'INTERNATIONAL FORM OF MEDICAL CERTIFICATE OF CAUSE OF DEATH'* DI HOSPITAL-HOSPITAL KEMENTERIAN KESIHATAN MALAYSIA

Dengan segala hormatnya perkara diatas adalah dirujuk.

2. Secara amnya prinsip keseragaman pengumpulan data dalam sistem kesihatan secara amat penting bagi memastikan segala data yang terlibat didalam penyampaian kesihatan adalah menurut kaedah yang sama dan seterusnya menghasilkan data sekunder serta analisa data yang lebih tepat.

3. Adalah didapati dalam penulisan dokumentasi klinikal dan seterusnya penetapan sebab-sebab kematian di hospital, tatacara penulisan yang dilakukan oleh Pegawai-pegawai Perubatan yang terlibat membuat dokumentasi kes-kes mortaliti adalah tidak seragam. Sehubungan itu, perkara ini dirasakan amat perlu diselaraskan. Untuk tujuan ini, adalah disyorkan semua hospital-hospital dibawah Kementerian Kesihatan Malaysia, menggunakan borang kematian seperti yang disyorkan oleh Pertubuhan Kesihatan Sedunia (World Health Organisation, WHO) seperti yang dinyatakan dalam Buku ICD10, Volume 2, versi 2010, seksyen 4.1.3, muka surat 32 bagi menentukan sebab kematian. Maklumat lain-lain keadaan yang menyebabkan kematian di ruangan 27(i)-27(viii) dalam Borang Daftar Masuk Dan Keluar Hospital PER-PD301 (Pin.2/2009) perlu dipindahkan ke dalam borang kematian yang dikeluarkan oleh WHO seperti di lampiran 1. Kepilkan borang ini bersama Borang Daftar Masuk Dan Keluar Hospital bagi kes kematian sebelum dihantar ke Jabatan/Unit Rekod Perubatan Hospital.

4. Penyeragaman penggunaan borang kematian ini, akan memudahkan proses kerja pemilihan *'Underlying Cause of Death'* yang dibuat oleh Pegawai dan Penolong Pegawai Tadbir (Rekod Perubatan). Ianya juga dapat memastikan semua maklumat penyakit yang dihidapi serta dirawat keatas pesakit sebelum kematian berlaku, tidak tertinggal. Adalah menjadi tanggungjawab pegawai perubatan yang menandatangani sijil kematian menentukan:

i. penyakit/keadaan morbid/kecederaan yang menjadi sebab langsung kematian;

ii. penyakit/keadaan morbid/ kecederaan yang membawa kepada sebab langsung kematian; dan

iii. penyakit/keadaan morbid/ kecederaan lain yang menyumbang kepada kematian.

5. Sehubungan itu, semua hospital di bawah Kementerian Kesihatan Malaysia adalah diarah menggunakan borang ***`International Form Of Medical Certificate Of Cause Of Death'*** berkuatkuasa pada **1 Januari 2015** .

6. Sukacita Y Bhg Datuk/Dato'/Datin/Tuan/Puan, dapat memanjangkan arahan penggunaan borang ini kepada semua hospital dibawah jagaan Y Bhg Datuk/Dato'/Datin/Tuan/Puan. Bersama ini disertakan contoh salinan borang kematian yang dikeluarkan oleh WHO (Lampiran 1) , tatacara penulisan (Lampiran 2) sebagai rujukan.

7. Jika terdapat sebarang pertanyaan mengenai perkara diatas, sila berhubung dengan Dr.Rusilawati Jaudin, Ketua Penolong Pengarah (Kanan), Unit Perkhidmatan Pengurusan Hospital, Bahagian Perkembangan Perubatan di talian 03-88831400 atau alamat e-mel rusilawati@moh.gov.my

Segala kerjasama yang diberikan oleh YBhg Datuk/Dato'/Datin/Tuan/Puan amatlah dihargai dan diucapkan terima kasih. Sekian.

"BERKHIDMAT UNTUK NEGARA"

Saya yang menurut perintah,

(DATUK DR.JEYAINDRAN TAN SRI SINNADURAI)
Timbalan Ketua Pengarah Kesihatan (Perubatan)
Kementerian Kesihatan Malaysia

s.k. Ketua Pengarah Kesihatan
Kementerian Kesihatan Malaysia

Pengarah
Bahagian Perancang

Pengarah
Bahagian Perkembangan Perubatan

SENARAI EDARAN

1. Pengarah Hospital
   Hospital Kuala Lumpur
   Kuala Lumpur

2. Pengarah Kesihatan Negeri
   Jabatan Kesihatan Negeri Perlis
   Perlis

3. Pengarah Kesihatan Negeri
   Jabatan Kesihatan Negeri Kedah
   Kedah

4. Pengarah Kesihatan Negeri
   Jabatan Kesihatan Negeri Pulau Pinang
   Penang

5. Pengarah Kesihatan Negeri
   Jabatan Kesihatan Negeri Perak
   Perak

6. Pengarah Kesihatan Negeri
   Jabatan Kesihatan Negeri Selangor
   Selangor

7. Pengarah Kesihatan Negeri
   Jabatan Kesihatan WP Kuala Lumpur
   Kuala Lumpur

8. Pengarah Kesihatan Negeri
   Jabatan Kesihatan Negeri Sembilan
   Negeri Sembilan

9. Pengarah Kesihatan Negeri
   Jabatan Kesihatan Negeri Melaka
   Melaka

10. Pengarah Kesihatan Negeri
    Jabatan Kesihatan Negeri Johor
    Johor

11. Pengarah Kesihatan Negeri
    Jabatan Kesihatan Negeri Pahang
    Pahang

12. Pengarah Kesihatan Negeri
    Jabatan Kesihatan Negeri Terengganu
    Terengganu

13. Pengarah Kesihatan Negeri
    Jabatan Kesihatan Negeri Kelantan
    Kelantan

14. Pengarah Kesihatan Negeri
    Jabatan Kesihatan Negeri Sarawak
    Sarawak

15. Pengarah Kesihatan Negeri
    Jabatan Kesihatan Negeri Sabah
    Sabah

16. Pengarah Kesihatan Negeri
    Jabatan Kesihatan Negeri WP Labuan
    Sabah

INTERNATIONAL FORM OF MEDICAL CERTIFICATE OF CAUSE OF DEATH

Cause of death		**Approximate interval between onset and death**
I Disease or condition directly leading to death*	(a)	.....
	due to (or as a consequence of)	
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b)	.....
	due to (or as a consequence of)	
	(c)	.....
	due to (or as a consequence of)	
	(d)	.....
II Other significant conditions contributing 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.*		

LAMPIRAN 2

Frequently used ill-defined terms

Accident	Specify **circumstances** Specify **intent**, as 'car accident' suicidal, or assault; Specify **place** of occurrence
Alcohol, drugs	Specify **use**: long term or single, addiction
Complication of surgery	Specify **disease**: disease that caused surgery
Dementia	Specify **cause**: Alzheimer, infarction, old age, other
Hepatitis	Specify **course, etiology**: acute or chronic, alcoholic If viral: specify Type (A, B, C, ...)
Infarction	Specify **site**: heart, brain, ... Specify **cause**: arteriosclerotic, thrombotic, embolic ...
Infection	Specify: primary or secondary, causative **organism** If **primary**: specify bacterial or viral If **secondary**: specify the primary infection
Leukaemia	Specify: acute, subacute, chronic lymphatic, myeloid, monocytic
Pneumonia	Specify: primary, aspiration, **cause**, causative organism If due to **immobility**: specify the cause of the immobility
Pulmonary embolism	Specify **cause**: cause of embolism If **post-surgical or immobility**: specify disease that caused surgery or immobility
Renal failure	Specify: acute, chronic or terminal, underlying **cause** of insufficiency, like arteriosclerosis, or infection If due to **immobility**: specify the cause of the immobility
Thrombosis	Specify: arterial or venous Specify: the blood **vessel** If **post-surgical or immobility**: specify disease that caused surgery or immobility
Tumour	Specify: behaviour, location, metastases
Urinary tract infection	Specify: **site** in the urinary tract, causative **organism**, underlying **cause** of infection If due to **immobility**: specify the cause of the immobility

ISBN xxxxxxxx

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World Health Organization

Cause of Death on the Death Certificate

In line with ICD-10

-Quick reference guide-

Cause of death information serves
- -epidemiology and prevention
- -managing health care
- -comparing health in different populations

Certification of death is one of the first steps in getting an overview of the health of people.

The diseases or conditions recorded on a death certificate represent the best medical opinion.

A properly completed cause-of-death certificate provides a description of the order, type and association of events that have resulted in the death.

The diagnoses reported on the certificate are coded with the International Classification of Diseases, 10th edition. This coded data is analyzed and used both nationally and internationally no matter what language was used to complete the certification.

Cause of Death on the certificate - how to fill in?

Death certificates may look different in most countries. But the section on the cause of death is identical world wide. That section has been designed by WHO, based on a century of experience. It has two parts, called Part I and Part II, and a section to record the time interval between the onset of each condition and the date of death.

Part I - is used for diseases or conditions that form part of the sequence of events leading directly to death.

The immediate (direct) cause of death is entered on the first line, I(a).
There must always be an entry on line I(a).
The entry on line Ia may be the only condition reported in Part I of the certificate.

Where there are two or more conditions that form part of the sequence of events leading directly to death. Each event in the sequence should be recorded on a separate line.

In any case you must record the disease, injury or external cause that resulted in the death. Do no record the mode of dying, such as cardiac arrest, respiratory failure or heart failure.

"Unknown" cause of death should be recorded in cases where thorough testing or autopsy examination cannot determine a cause of death. "Unknown" is better than any speculation on the possible cause of death.

Always fully spell out all terms. Abbreviations can be interpreted in different ways. Terms such as "suspected" or "possible" are ignored in evaluation of the entries. For example "suspected Diabetes" will be interpreted as "Diabetes".

The four lines may not provide enough space for the chain of events. Do not waste space with unnecessary words. Some clinical terms are very vague. For example, "tumour" does not specify behaviour (see also last page of this flyer).

Duration - is the time interval between the onset of each condition that is entered on the certificate (not the time of diagnosis of the condition), and the date of death. The duration information is useful in coding certain diseases and also provides a useful check on the order of the reported sequence of conditions.

Part II - is used for conditions which have no direct connection with the events leading to death but whose presence contributed to death.

Cause of Death on the certificate - step by step

Start at line I(a), with the immediate (direct) cause, then go back in time to preceding conditions until you get to the one that started the sequence of events. You will get very close to the time the patient was healthy.

Now, you should have reported the underlying or originating cause on the lowest used line and a sequence of events leads from the underlying cause up to the immediate (direct) cause in the first line I(a).

Finally, record the time interval between the onset of each condition entered on the certificate and the date of death. Where the time or date of onset is not known you should record a best estimate. Enter the unit of time (minutes, hours, days, weeks, months, years).

Example

	Cause of death	Approximate interval between onset and death
I Disease or condition directly leading to death *)	(a) Cerebral haemorrhage due to (or as a consequence of)	4 hours
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b) Metastasis of the brain due to (or as a consequence of)	4 months
	(c) Breast cancer due to (or as a consequence of)	5 years
	(d)	
II Other significant conditions contributing to death, but not related to the disease or conditions causing it	Arterial hypertension Diabetes mellitus	3 years 10 years

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

- **Write clearly** and do not use abbreviations.
- Be sure the information is complete.
- **Do not speculate** on the cause of death; rather record "cause unknown".
- Do not fill in laboratory results or statements like "found by wife".
  (there may be separate fields on the form for this kind of information)
- One condition per line should be sufficient.