



Pharmacy Information System (PhIS) and Clinic Pharmacy System (CPS)

User Manual Medication Therapy Adherence Clinic (MTAC)

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Document ID	: U. MANUAL_MTAC



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Application reference: PhIS & CPS v2.5.1



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1.0 Introduction

1.1 Overview of PhIS

Pharmacy Information System or better known as PhIS, is a complete and comprehensive system that integrates pharmacy related services geared towards pharmacy excellence. PhIS implementation would transform most of current manual process to electronic system to benefit facility end user in the health care sector.

There are 12 modules to assist services delivery by the health care sector which comprises of:

1. Order Management
2. Inpatient Pharmacy
3. Outpatient Pharmacy
4. Medication Counselling
5. Ward Pharmacy
6. Pharmacy Inventory
7. Manufacturing of Cytotoxic Drug Reconstitution, Parenteral Nutrition, IV Admixture & Eye Drop, Radiopharmaceuticals and Extemporaneous
8. Adverse Drug Reaction & Drug Allergic (ADR & DAC)
9. Clinical Pharmacokinetics Services (TDM)
10. Drug Information & Consumer Education (DICE)
11. Medication Therapy Adherence Clinic (MTAC)
12. Data Mining (PhARM)

1.2 Purpose and Objectives

This user manual outlines the Medication Therapy Adherence Clinic (MTAC) sub-module and its key features and functionalities. The primary objective is to guide user through the process of completing PhIS application process.

User will understand the following activities in detail:

- MTAC Reporting





















1.3 Organised Sections

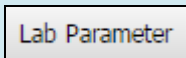
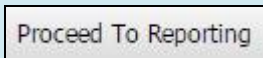
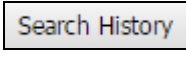




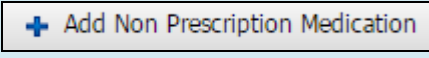

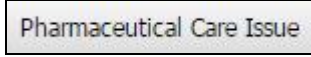

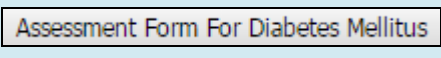


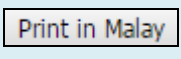
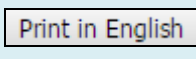
These are the sections within this document:

- Section 1 : Introduction
- Section 2 : Application Standard Features
- Section 3 : MTAC
- Section 4 : Acronyms
- Section 5 : Links to clinical modules

2.0 Application Standard Features

2.1 PhIS Legend

Standard Legend			
<input type="text"/>	Blank Field	<input type="text" value="v"/>	Drop Down Box
	Reset Login	<input type="button" value="LOGIN"/>	Login to PhIS
	Expand Menu		Collapse Menu
<input type="button" value="Home"/>	Display Home Tab		Expand Module
	Collapse Module	<input type="button" value="Logout"/>	Logout from PhIS
	Close All Tabs		Refresh
	Search First Page/ Previous Page		Search Next Page/Last Page
	Search Up/Down Button	<input type="text" value="F02FBW-0003984"/>	Hyperlink
	Save		Show Help
	Search Icon		Add/Create New Record
	Calendar Icon	<input type="button" value="Search"/>	Search Record
	Close Window	<input type="button" value="Add/Update"/>	Add/Update Button
<input type="text" value="HPSF00088304"/>	Auto generate an information by the system	<input type="text" value="SPUB5656569"/>	Auto generate record no by the system
*	Mandatory Field	<input type="button" value="Cancel"/>	Cancel Button
<input type="button" value="Yes"/>	Yes Button	<input type="button" value="No"/>	No Button
<input type="button" value="OK"/>	OK Button		Edit Record
	Print	<input type="button" value="Export to Excel"/>	Export report from PDF to Excel
<input type="checkbox"/>	Check Box	<input type="radio"/>	Radio Button
	Cancel		Delete Record

MTAC Module Legend			
	Lab Parameter Button		Proceed To Reporting Button
	Search History Button	Audit Trail	Audit Trail Hyperlink
	Consent Form Button		CP1 Button
	CP4 Button		Add Prescription Medication Button
Calculate Score	Calculate Score Hyperlink		Add Non Prescription Medication Button
	Save & Continue Button		Pharmaceutical Care Issue Button
	Malay Language Button		Assessment Form for Diabetes Mellitus Button
	Medication Order Button		Confirm Button
	Print In Malay Button		Print In English Button

Note

To learn more about Login Information, kindly click [Login Information](#) module for descriptive steps.

3.0 MTAC

Overview

The MTAC module emphasis on medication management to improve quality and safety include. Implementing safe, organized, and efficient drug-dispensing systems is essential for controlling costs and assuring that the medical prescription is safely followed as requested and within the relevant deadline. An appropriate dispensing system and cost-effectiveness of patient care. MTAC is operated to drug therapy monitoring and patient's education in improving their ability to successfully manage disease condition and reducing medication error.

User Group

This module is intended for registration staff and pharmacist (subject to the user assigned by the facility)

Functional Diagram

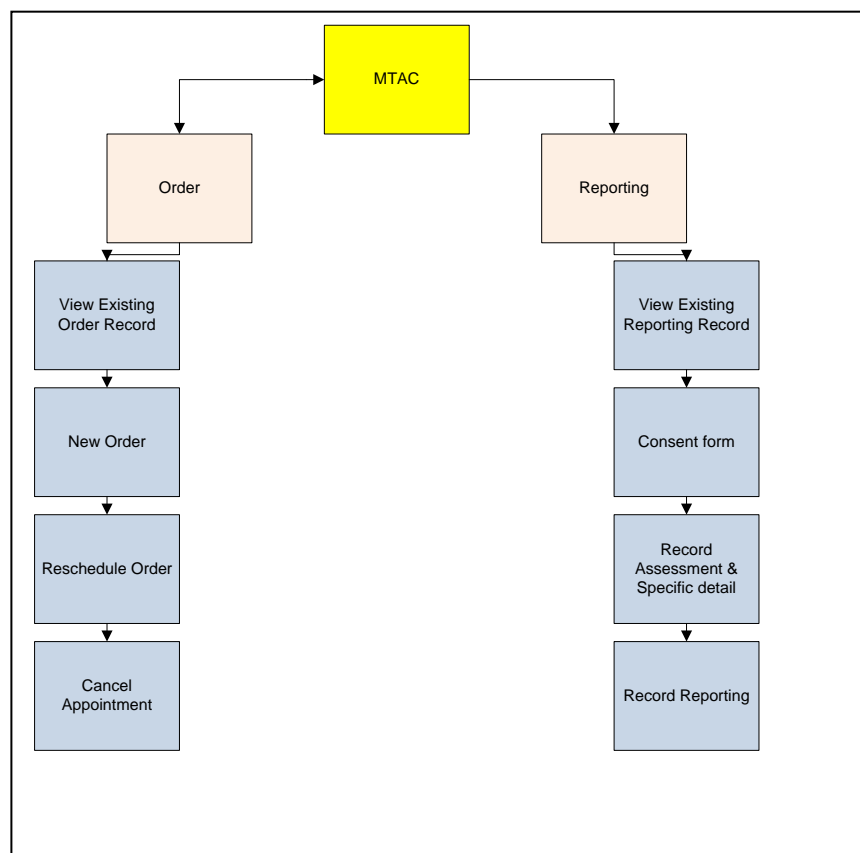


Figure 3.0-1

Functional Description:

MTAC Reporting

MTAC Reporting is to record the type of MTAC for counselling and to schedule appointment dates. Reporting is used to record assessment, specific details and report of counselling

There are ten (8) types of MTAC with No Specific Details

1. Cardiac Rehab Program



2. Chronic Pain
3. Gastrohepatology
4. Hepatitis
5. Neurology
6. Osteoporosis
7. Psychiatry
8. Rheumatology

There are ten (14) types of MTAC with Specific Details

1. Chronic Kidney Disease
2. Diabetes Mellitus
3. Dialysis
4. Geriatric
5. Heart Failure
6. Methadone
7. Renal Transplant
8. Respiratory
9. Retro Viral Disease
10. Warfarin
11. Cardiovascular Care Bundle
12. Hemophilia
13. Psoriasis
14. Thalassemia

3.1 MTAC

Order will be ordered by prescriber from order management. Pharmacists are also able to create a new order at the MTAC Reporting screen

3.1.1 View Existing Order at MTAC Reporting

MTAC Reporting screen allow users to search and view existing patients' MTAC order records.

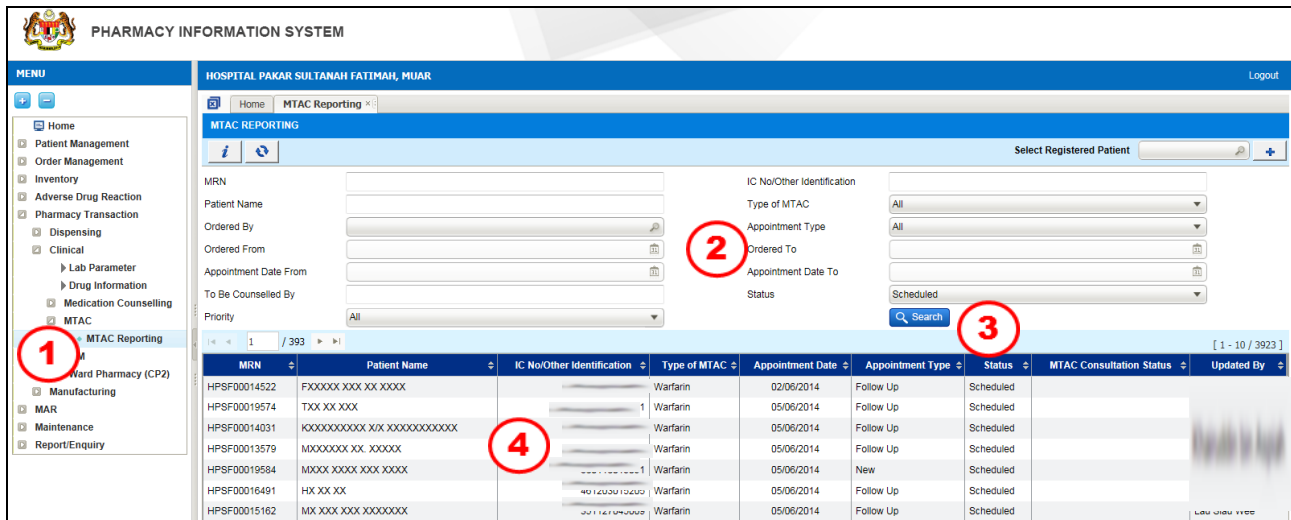


Figure 3.1.1-1 MTAC Reporting Listing Page

STEP 1

Click on 'Pharmacy Transaction' menu followed by 'Clinical' then 'MTAC' and 'MTAC Reporting' sub menu

STEP 2

Search existing patient record by: -

Field	Description	Remark
MRN	Patient Medical Record Number	Search option: Type the MRN either full or partial: Example: HPSF00001234 or "1234"
Patient Name	Patient Name	Allow to search by patient full name or partial
Ordered by	Ordered by	Able to filter and search by ordered by
Ordered from	Ordered from	Able to filter and search by ordered from
Appointment Date From	Appointment Date From	Able to filter and search by appointment date before
To Be Counselling by	To Be Counselling by	Able to filter and search by to be counselling by
Priority	- All - Urgent - Routine	Able to filter and search by priority
ID No/ Other Identification	Identification Number	Allow to search by full or partial ID Number
Type of MTAC	- All - Cardiac Rehab Program	Able to filter and search by type of MTAC order

	<ul style="list-style-type: none"> - Chronic Kidney Disease - Chronic Pain - Diabetes Mellitus - Dialysis - Gastrohepatology - Geriatric - Hemophilia - Heart Failure - Hepatitis - Methadone - Neurology - Osteoporosis - Psoriasis - Psychiatry - Renal Transplant - Respiratory - Retro Viral Disease - Rheumatology - Warfarin -Thalassemia 	
Appointment Type	<ul style="list-style-type: none"> - All - Follow Up - New 	Able to filter and search by appointment type
Ordered to	Ordered to	Able to filter and search by ordered to
Appointment Date To	Appointment Date To	Able to filter and search by appointment date the latest
Status	<ul style="list-style-type: none"> - All - Ordered - Scheduled - Cancelled - In Progress - Completed 	Able to filter and search by status

Table 3.1.1-1

STEP 3

Click on the  button to search the patient

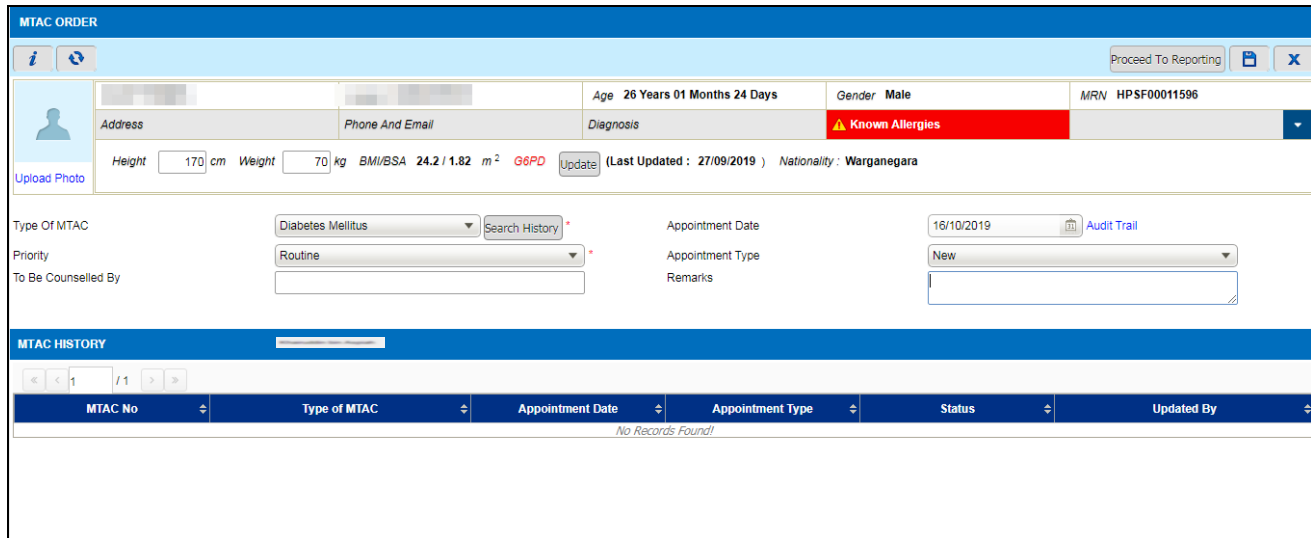
Note

Search result of current order patient list will be displayed:

- MRN
- Patient Name
- ID No
- Type of MTAC
- Appointment Date
- Appointment Type
- Status
- Updated By

STEP 4

Double click on the selected patient's name and Order record will be displayed



The screenshot displays the 'MTAC ORDER' form. At the top, there are navigation icons and a 'Proceed To Reporting' button. The patient banner includes fields for Name, Address, Phone And Email, Age (26 Years 01 Months 24 Days), Gender (Male), and MRN (HPSF00011596). A red box highlights 'Known Allergies'. Below this, physical attributes like Height (170 cm), Weight (70 kg), BMI/BSA (24.2 / 1.82 m²), and G6PD are shown, along with an 'Update' button and 'Nationality: Warganegara'. The form also has sections for 'Type Of MTAC' (Diabetes Mellitus), 'Priority' (Routine), 'Appointment Date' (16/10/2019), and 'Appointment Type' (New). A 'Remarks' field is also present. At the bottom, the 'MTAC HISTORY' section shows a table with columns: MTAC No, Type of MTAC, Appointment Date, Appointment Type, Status, and Updated By. The table currently displays 'No Records Found!'.

Figure 3.1.1-2 MTAC Order

Note

- Once click on the selected patient name, the summary of patient information will be displayed in the patient banner. The patient banner will be displayed at the specific screen which is required patient information. Below is the list of patient information:
 - Patient Name
 - Patient Address
 - Patient IC No
 - Patient Phone and Email
 - Patient Age
 - Patient Diagnosis
 - Patient Gender
 - Patient Allergy
 - Patient MRN
- Below options are provided for user to view the additional patient's information. Click on the hyperlink as below:
 - a) **Monitoring Parameter**
 - Patient's laboratory test results and standard parameter results for laboratory test
 - b) **Counselling History**
 - Patient's previous medication counselling history records
 - c) **MTAC History**
 - Patient's previous MTAC History records
 - d) **Demographic**
 - Patient's demographic details
 - e) **Pharmacist Notes**
 - Pharmacist notes according to type of service such as CP1, CP2, MTAC, TDM and etc
 - f) **Medication Profile**

- *Patient's current medication and previous medication history records*

g) **Other Appointments**

- *Provides information if there are any other appointments recorded for the patient*

• *MTAC Order Details will be displayed as below:*

- *MTAC Order No – Auto generated by system*
- *Type of MTAC*
- *Priority*
- *To Be Counselling By*
- *Ordered By*
- *Status - Status of the order*
- *Appointment Date*
- *Appointment Type*
- *Remarks*
- *Ordered Date/Time*

• *Search result of MTAC History order list of the patient will be displayed:*

- *MTAC No*
- *Type of MTAC*
- *Appointment Date*
- *Appointment Type*
- *Status*
- *Updated By*

• *User able to edit and schedule MTAC Order. Status will be defaulted as Scheduled*

3.1.2 Create New MTAC Order

This function allows user to create a new order for MTAC patients.

Figure 3.1.2-1 MTAC Reporting Listing Page

STEP 1

Click on 'Pharmacy Transaction' menu followed by 'Clinical' then 'MTAC' and 'MTAC Reporting' sub menu

STEP 2

Click on the button to search for registered patient at the

Figure 3.1.2-2 Patient Search

Note

- Search MRN screen will be displayed as per Figure Patient search screen will be displayed as shown in Figure 3.1.2-2
- On this screen, user will be able to search existing patient record by:
 - a) MRN
 - b) Patient Name
 - c) Ordered By
 - d) Ordered From
 - e) Appointment Date
 - f) To Be Counseled By
 - g) ID No
 - h) Type of MTAC
 - i) Appointment Type
 - j) Ordered To
 - k) Priority
 - l) Status
- User able to view the list of MTAC order at the listing page as per Figure 3.1.2-2
- If need to re-schedule the order again, click on the selected patient name and continue to proceed re-schedule process.


STEP 3

Search existing patient record as follow: -

Field	Description	Remark
Patient MRN	Patient Medical Record Number	Search option: Type the MRN either in full or partially: <i>Example: HPSF00001234 or "1234"</i>
Patient Name	Patient's name	Allow to search by full or partial patient name
ID No	Identification Number	Allow to search by full or partial ID Number

Table 3.1.2-1

STEP 4

Click on the  button to search for the patient and system will display all the registered patients

STEP 5

Click on  button to add a new MTAC order record as Figure 3.1.2-3

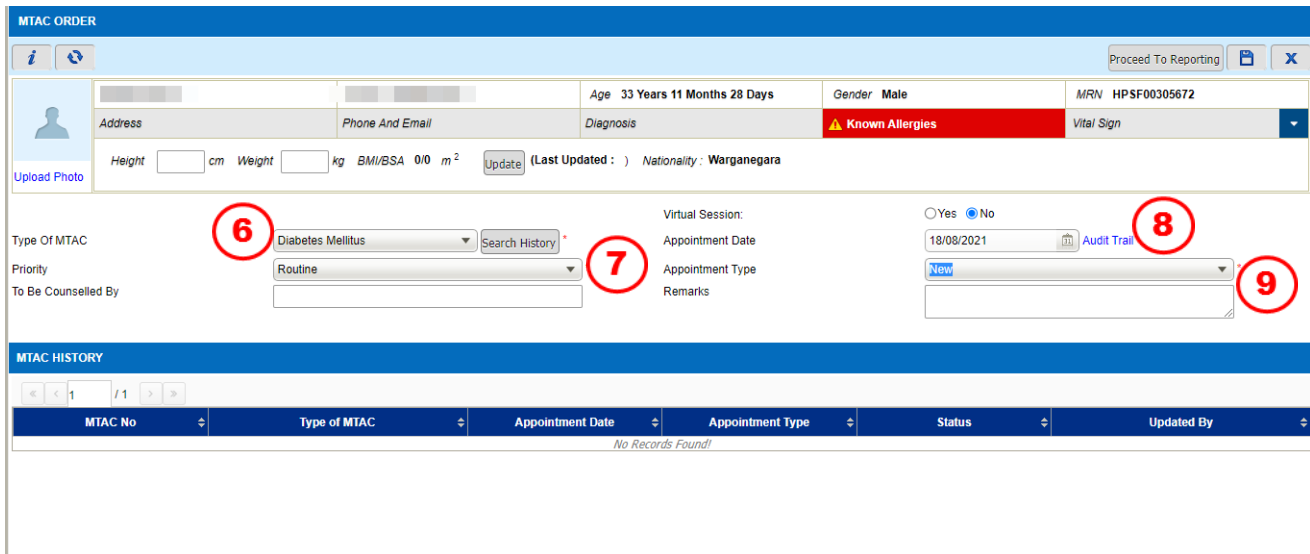


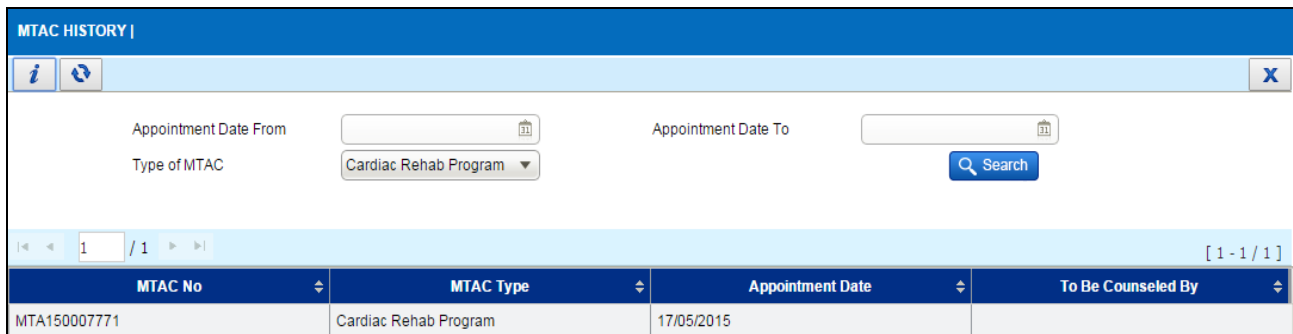
Figure 3.1.2-3 MTAC Order

STEP 6

Select **Type Of MTAC** from the drop-down box

Note

- Virtual session radio button to be selected if a virtual MTAC Order session is being ordered
- **Type of MTAC** listed depends on the facility's MTAC availability.
- Select **Type of MTAC** and click on the **Search History** button. System will display previous MTAC History details (according to the selected MTAC type) in the pop up window as shown in Figure 3.1.2-4.
- MTAC History will also be listed at the bottom of the 'MTAC Order' screen.



MTAC No	MTAC Type	Appointment Date	To Be Counseled By
MTA150007771	Cardiac Rehab Program	17/05/2015	


Figure 3.1.2-4 MTAC History

STEP 7

Select **Priority** as listed from the drop down box

- Routine
- Urgent

STEP 8

Click on the  button to select **Appointment Date**

Note

Appointment Date [Audit Trail](#)

Sep 2016						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
28	29	30	31	1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	1

- Click on the [Audit Trail](#) hyperlink to view a list of changes/amendment on the same MTAC report if there is any.
- User is allow to select the date from 5 days back. For example today is **5/9/2016**, user can select **31 Aug, 1, 2, 3 and 4 Sept**.

STEP 9

Select **Appointment Type** as listed from the drop-down box

- New
- Follow Up

Note

- User will be able to enter **To Be Counseled By** person name and **Remarks** if required.
- The **Status** of the order will be changed to 'Scheduled' if the **Appointment Date** is selected.
- Additional information will be displayed for the **Type of MTAC** 'Warfarin' as below:
 - Target INR Range
 - Date Warfarin Started
 - Warfarin Indication
 - Anticipated Duration
 - Bleeding Risk Factor
 - Time in Therapeutic Range (TTR)
- User can click on the button to save the MTAC Order and system will proceed to 'MTAC Reporting' window.
- Assessment section is automatically copied from the previous/latest visit.
- 'Specific details' will be automatically copied from the latest record only for the same **Type of MTAC**.

Figure 3.1.2-5 MTAC Order

STEP 10

Click on the  button to save the record

STEP 11

Click on the  button to confirm saving of order

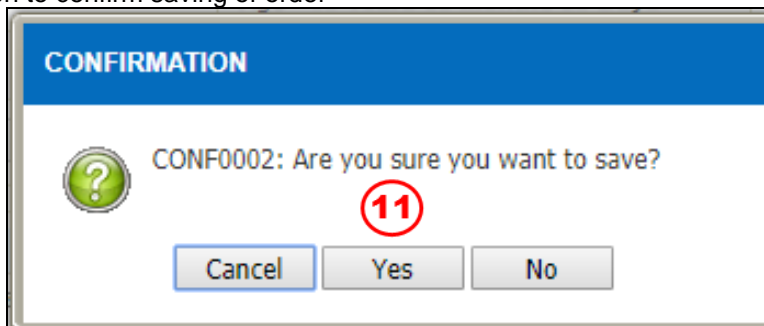



Figure 3.1.2-6 Confirmation Alert Message

STEP 12

Click on the  button to confirm record

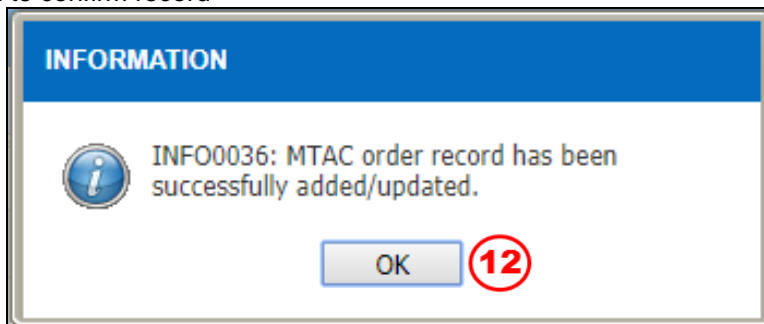
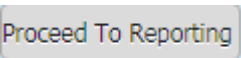


Figure 3.1.2-7 Information Alert Message

STEP 13

Click on the  button to proceed to reporting screen as shown in Figure 3.1.2-5

3.1.3 Reschedule MTAC Order

This function is used to reschedule MTAC appointment date

MTAC ORDER

Proceed To Reporting [Edit] [Close]

Age 33 Years 11 Months 28 Days Gender Male MRN HPSF00305672 **1**

Address Phone And Email Diagnosis **Known Allergies** Vital Sign

Height [] cm Weight [] kg BMI/BSA 0/0 m² Update (Last Updated :) Nationality : Warganegara

MTAC Order No: MTA210004814 Virtual Session: Yes No **2**

Type Of MTAC: Diabetes Mellitus Appointment Date: 18/08/2021 Audit Trail

Priority: Routine Appointment Type: New

To Be Counselling By: [] Remarks: []

Ordered By: [] Ordered Date/Time: 18/08/2021 06:46

Status: Scheduled

MTAC HISTORY

MTAC No	Type of MTAC	Appointment Date	Appointment Type	Status	Updated By
MTA210004814	Diabetes Mellitus	18/08/2021	New	Scheduled	

Figure 3.1.3-1 MTAC Order

Note

Repeat **STEP 1** to **4** as in section [3.1.1 View Existing Order](#) before performing reschedule MTAC order for patient.

STEP 1

Click on the button to edit MTAC order

STEP 2

Click on the button to select a different **Appointment Date**

Note

- User will be able to edit **Appointment Date** at 'MTAC Order' screen only before the MTAC Reporting is saved.
- Click on the [Audit Trail](#) hyperlink to view a list of changes/amendment on the same MTAC report if there is any.

MTAC ORDER

Proceed To Reporting [Save] [Close]

Age 33 Years 11 Months 28 Days Gender Male MRN HPSF00305672 **3**

Address Phone And Email Diagnosis **Known Allergies** Vital Sign

Height [] cm Weight [] kg BMI/BSA 0/0 m² Update (Last Updated :) Nationality : Warganegara

MTAC Order No: MTA210004814 Virtual Session: Yes No

Type Of MTAC: Diabetes Mellitus Appointment Date: 19/08/2021 Audit Trail

Priority: Routine Appointment Type: New

To Be Counselling By: [] Remarks: []

Ordered By: [] Ordered Date/Time: 18/08/2021 06:46

Status: Scheduled

MTAC HISTORY

MTAC No	Type of MTAC	Appointment Date	Appointment Type	Status	Updated By
MTA210004814	Diabetes Mellitus	18/08/2021	New	Scheduled	

Figure 3.1.3-2 MTAC Order

STEP 3

Click on the  button to save the record

STEP 4

Click on the  button to confirm saving of order

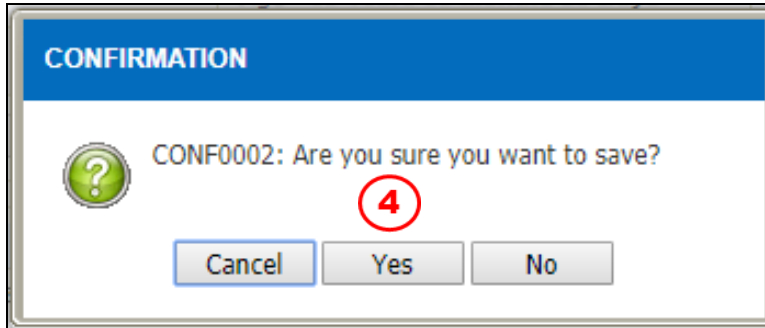



Figure 3.1.3-3 Confirmation alert message

STEP 5

Click on the  button to confirm record

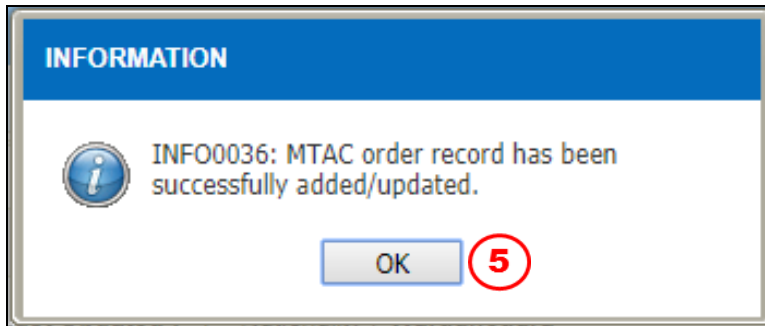



Figure 3.1.3-4 Information alert message

STEP 6

Click on the  button to close record as shown in Figure 3.1.3-5

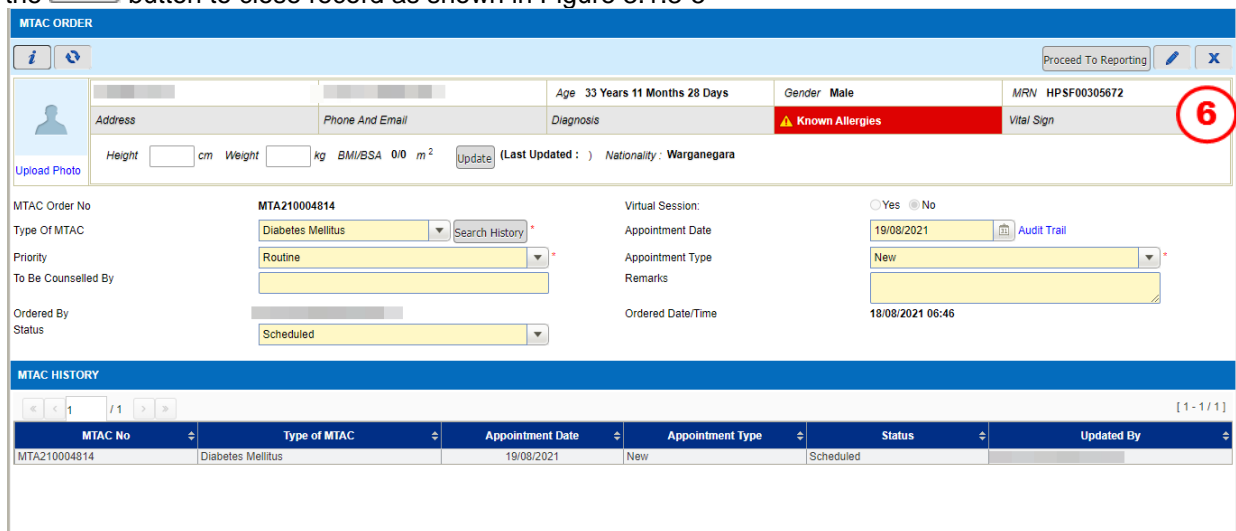


Figure 3.1.3-5 MTAC Order

3.1.4 Cancel MTAC Order

This function is used to cancel an existing MTAC order

MTAC ORDER

Proceed To Reporting [Edit] [Close]

Age 33 Years 11 Months 28 Days Gender Male MRN HPSF00305672 **1**

Address Phone And Email Diagnosis **Known Allergies** Vital Sign

Height [] cm Weight [] kg BMI/BSA 0/0 m² [Update] (Last Updated :) Nationality : Warganegara

MTAC Order No: MTA210004814 Virtual Session: Yes No

Type Of MTAC: Diabetes Mellitus [Search History] Appointment Date: 18/08/2021 [Audit Trail]

Priority: Routine [] Appointment Type: New []

To Be Counseled By: [] Remarks: []

Ordered By: [] Ordered Date/Time: 18/08/2021 06:46

Status: Scheduled **2**

MTAC HISTORY

MTAC No	Type of MTAC	Appointment Date	Appointment Type	Status	Updated By
MTA210004814	Diabetes Mellitus	18/08/2021	New	Scheduled	

Figure 3.1.4-1 MTAC Order

Note

Repeat **STEP 1** to **4** as in section [3.1.1 View Existing Order](#) to cancel an existing MTAC order for patient.

STEP 1

Click on the button to edit MTAC order

STEP 2

Select **Status** as 'Cancelled' from the drop down box

Note

- User will be able to cancel order at 'MTAC order' screen only before the MTAC Reporting is saved.
- Only order with **Status** 'Ordered' and 'Scheduled' can be cancelled.

CANCEL REMARKS

[Save] [Close]

[] **3** **4**

Figure 3.1.4-2 Cancel Remarks

STEP 3

Enter **Cancel Remarks** and save the record

STEP 4

Click on the button to save record

STEP 5

Click on the button to confirm saving of order

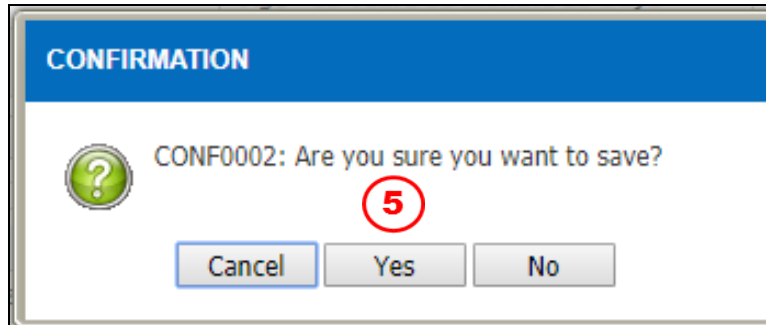


Figure 3.1.4-3 Confirmation Alert Message

STEP 6

Click on the button to confirm record

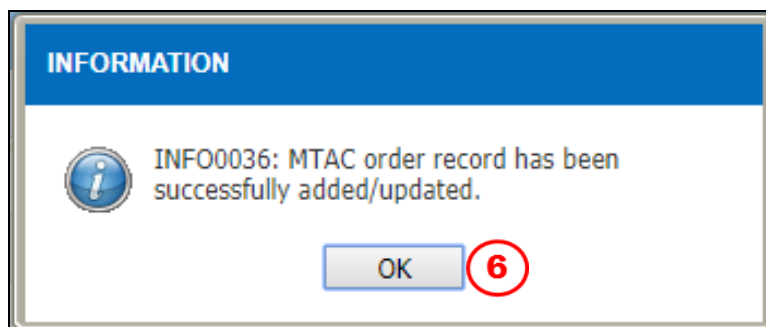


Figure 3.1.4-4 Information Alert Message

3.2 MTAC Reporting

This function is used to search and view existing MTAC reporting or record new MTAC reporting

3.2.1 Create New MTAC Reporting With No Specific Details

This function allow user to record new MTAC reporting with no specific details for MTAC patient

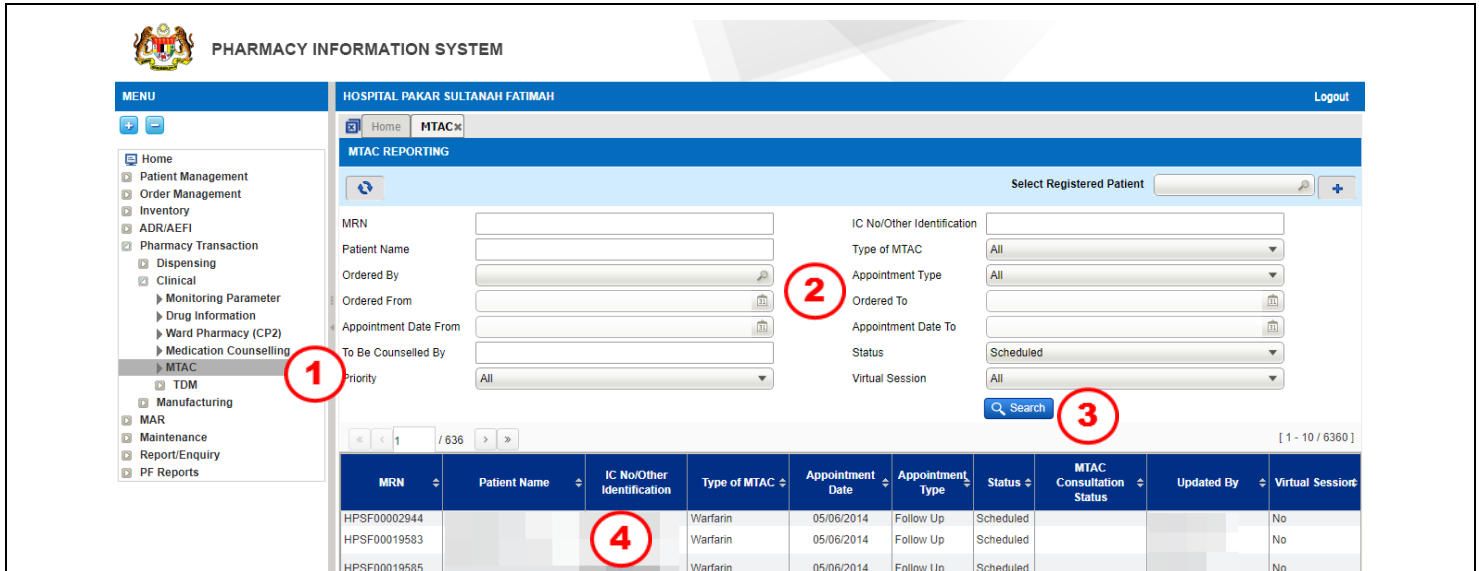


Figure 3.2.1-1 MTAC Reporting Listing Page

STEP 1

Click on 'Pharmacy Transaction' menu followed by 'Clinical' then 'MTAC' sub menu

STEP 2

Search for existing patient record by below criteria:

Field	Description	Remark
MRN	Patient Medical Record Number	Search option: Type the MRN either full or partial: Example: HPSF00001234 or "1234"
Patient Name	Patient Name	Allow to search by patient full name or partial
Ordered by	Ordered by	Able to filter and search by ordered by
Ordered from	Ordered from	Able to filter and search by ordered from
Appointment Date From	Appointment Date From	Able to filter and search by appointment date before
To Be Counsellled by	To Be Counsellled by	Able to filter and search by to be counsellled by
Priority	- All - Urgent - Routine	Able to filter and search by priority
ID No/ Other	Identification Number	Allow to search by full or partial ID Number

Identification		
Type of MTAC	<ul style="list-style-type: none"> - All - Cardiac Rehab Program - Chronic Kidney Disease - Chronic Pain - Diabetes Mellitus - Dialysis - Gastrohepatology - Geriatric - Hemophilia - Heart Failure - Hepatitis - Methadone - Neurology - Osteoporosis - Psoriasis - Psychiatry - Renal Transplant - Respiratory - Retro Viral Disease - Rheumatology - Warfarin -Thalassemia 	Able to filter and search by type of MTAC order
Appointment Type	<ul style="list-style-type: none"> - All - Follow Up - New 	Able to filter and search by appointment type
Ordered to	Ordered to	Able to filter and search by ordered to
Appointment Date To	Appointment Date To	Able to filter and search by appointment date the latest
Status	<ul style="list-style-type: none"> - All - Ordered - Scheduled - Cancelled - In Progress - Completed 	Able to filter and search by status

Table 3.2.1-1

STEP 3

Click on the  button to search the patient

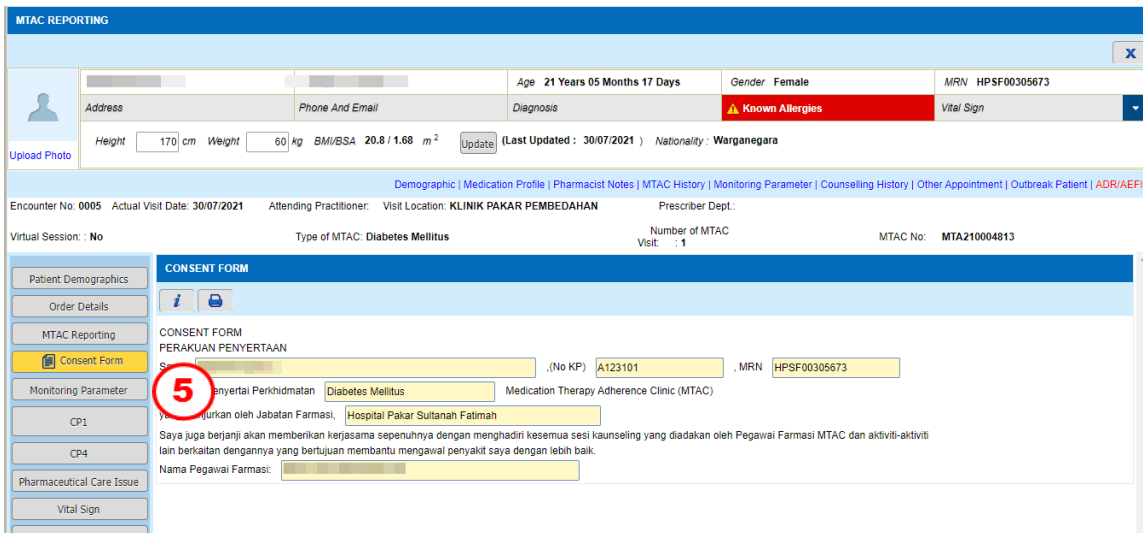
Note

Search results of current order patient list will display:

- MRN
- ID No
- Patient Name
- Type of MTAC
- Appointment Date
- Appointment Type
- Status
- MTAC Consultation Status
- Updated By

STEP 4


Double click on the selected patient's record and click at  and the 'Consent Form' window will be displayed as shown in Figure 3.2.1-2




The screenshot shows the 'MTAC REPORTING' interface. At the top, there's a patient summary with fields for Age (21 Years 05 Months 17 Days), Gender (Female), MRN (HPSF00305673), and a 'Known Allergies' warning. Below this, there are tabs for Patient Demographics, Order Details, MTAC Reporting, and Monitoring Parameter. The 'Consent Form' window is open, showing a 'PERAKUAN PENYERTAAN' (Consent Form) for a patient with Diabetes Mellitus. The patient's name is highlighted in yellow, and a red circle with the number 5 is around the patient's name field.

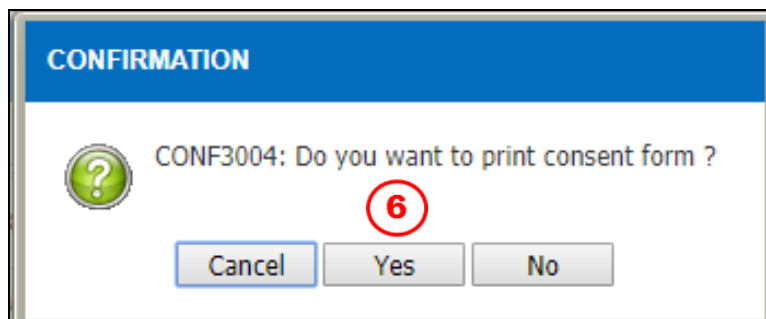
Figure 3.2.1-2 Consent Form

STEP 5

Click on the  button to print the consent form

STEP 6

Click on the  to confirm printing Consent form and new screen will be displayed for user to print Consent Form as per Figure 3.2.1-4



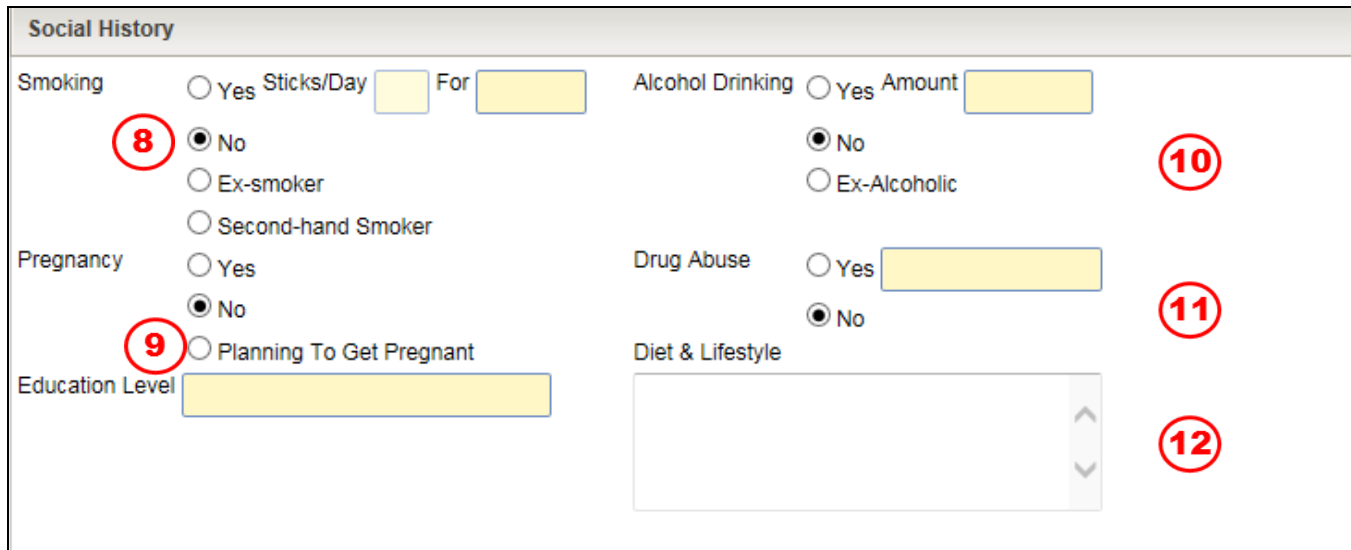
The screenshot shows a 'CONFIRMATION' dialog box with a question mark icon. The text reads 'CONF3004: Do you want to print consent form?'. Below the text are three buttons: 'Cancel', 'Yes', and 'No'. The 'Yes' button is highlighted with a red circle and the number 6.

Figure 3.2.1-3 Print Report Alert Message

Social History

STEP 7

Enter **Estimated Dry Body Weight in Kg**



Social History

Smoking Yes Sticks/Day For No Ex-smoker Second-hand Smoker

Pregnancy Yes No Planning To Get Pregnant

Education Level

Alcohol Drinking Yes Amount No Ex-Alcoholic

Drug Abuse Yes No

Diet & Lifestyle

Figure 3.2.1-6 MTAC Reporting – Assessment on Social History

STEP 8

Select on **Smoking** radio button

- Yes
- No
- Ex-smoker
- Second-hand Smoker

Note

Sticks/Day and for fields will be enabled only if user select Yes and Ex-smoker radio button

STEP 9

Select on **Pregnancy** radio button

- Yes
- No
- Planning to Get Pregnant

STEP 10

Select on **Alcohol Drinking** radio button

- Yes
- No
- Ex-Alcoholic

Note

Amount field will be enabled if user select 'Yes' radio button

STEP 11

Select **Drug Abuse** radio button

- Yes
- No

Note

Blank field will be enabled if user select 'Yes' radio button

STEP 12

Enter **Diet & Lifestyle**

Note

- **Pregnancy** field will only be available for married female
- **Education Level** and **Marital Status** information will be retrieved from Patient's Demographic

Family History

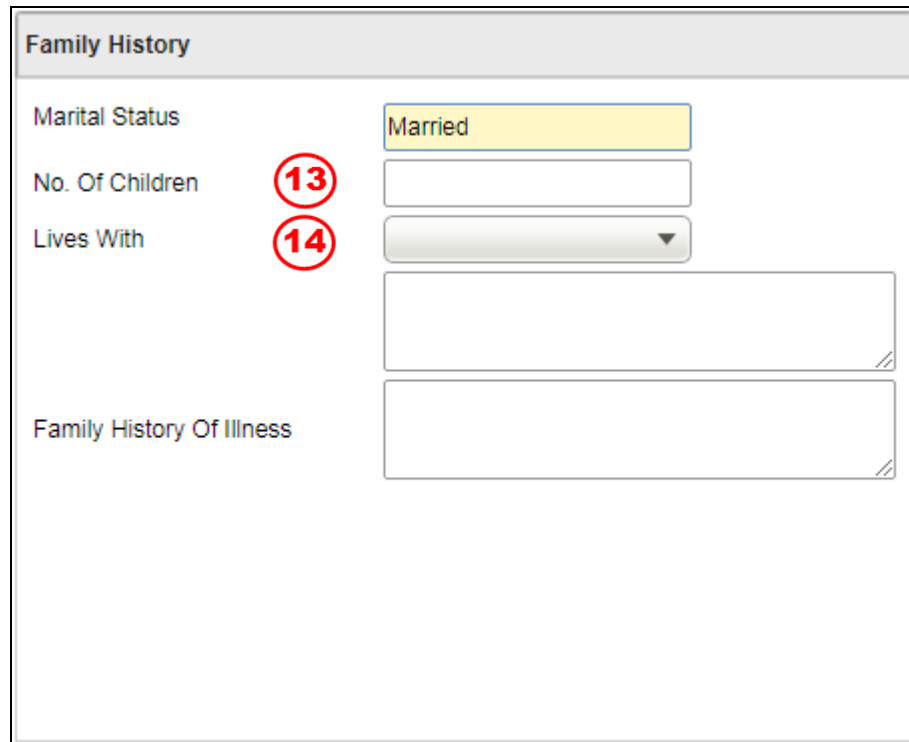


Figure 3.2.1-7 MTAC Reporting – Assessment on Family History

STEP 13

Enter **No. Of Children**

STEP 14

Select **Lives with** from the drop-down box

- Alone
- Family Members
- Nursing Home
- Others

Note

- Blank fields will be enable for all types of **Lives with** selected
- Enter **Family History of Illness** if available

Medical History

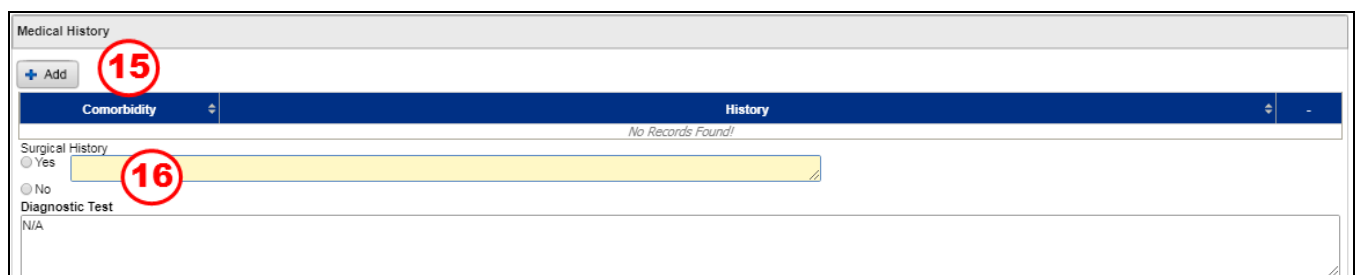




Figure 3.2.1-8 MTAC Reporting – Assessment on Medical History

STEP 15

Click  button and select any **Comorbidity** from drop-down menu and Fill up at **History** field.

Note

- User can enter multiple Comorbidity record by click  button.
- There are several type **Comorbidity**:
 - Hypertension
 - Diabetes Mellitus
 - Tuberculosis
 - AF
 - Asthma
 - Hepatitis B
 - Hepatitis C
 - Heart Failure
 - ESRD
 - COPD
 - RVD
 - Other
- **The History field can be free text 500 characters**

STEP 16

Select **Surgical History** radio button

- Yes
- No

Note

- If yes selected for Surgical History, user can enter remarks at free text column with maximum 500 characters
- User can enter Diagnosis Test that already change to 1 box only and can be fill up 2000 characters.

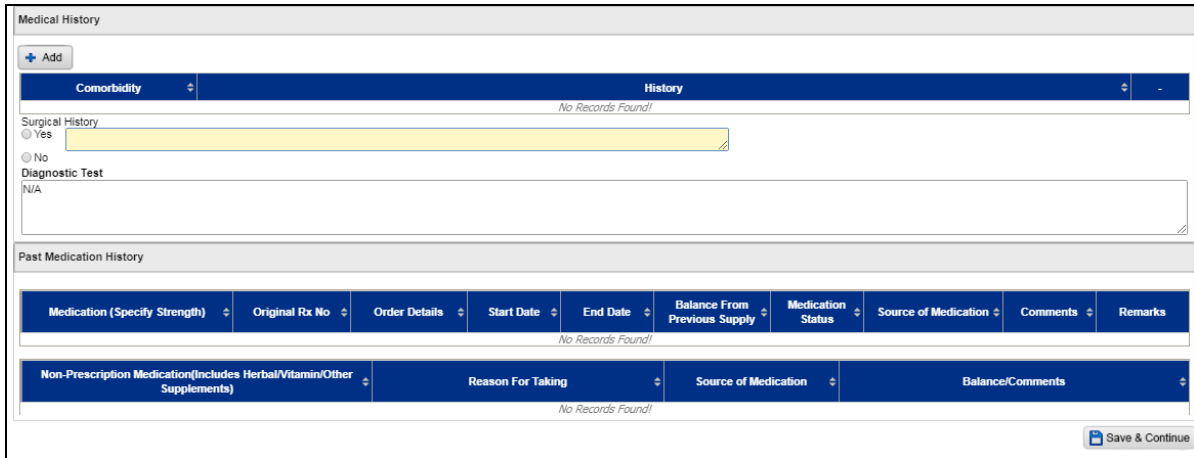
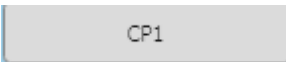
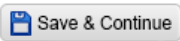


Figure 3.2.1-9 MTAC Reporting – Assessment on Past Medication History

Note

Click on the  button to add 'Past Medication History' as shown in Figure 3.2.1-9. Further details in Section 3.2.2 Other Tabs

STEP 17

Click on the  button as shown in Figure 3.2.1-10 to save assessment and continue with reporting section

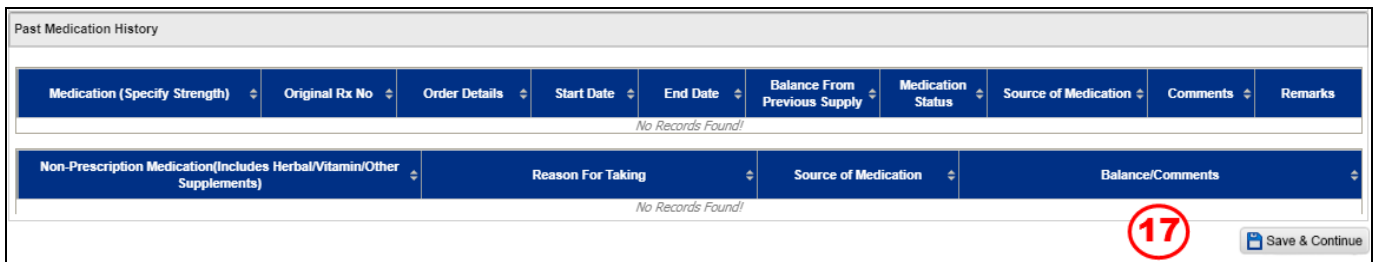


Figure 3.2.1-10 MTAC Reporting – Assessment Past Medication History

STEP 18

Click on the  button to confirm

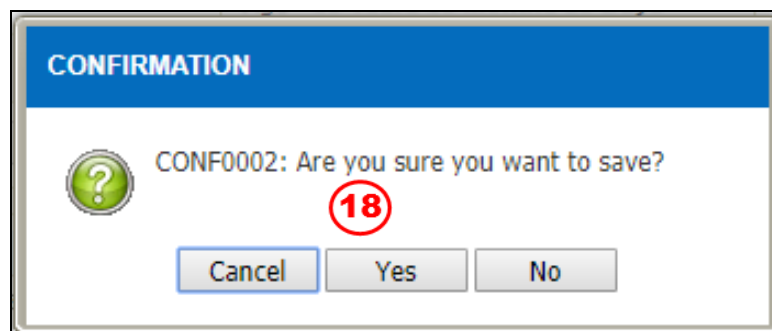


Figure 3.2.1-11 Confirmation Alert Message

STEP 19

Click on the  button to confirm record

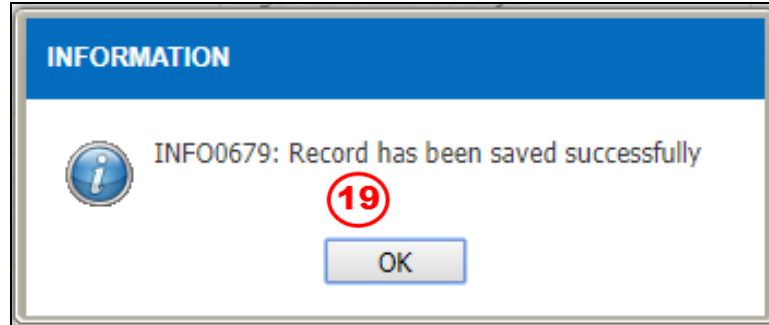
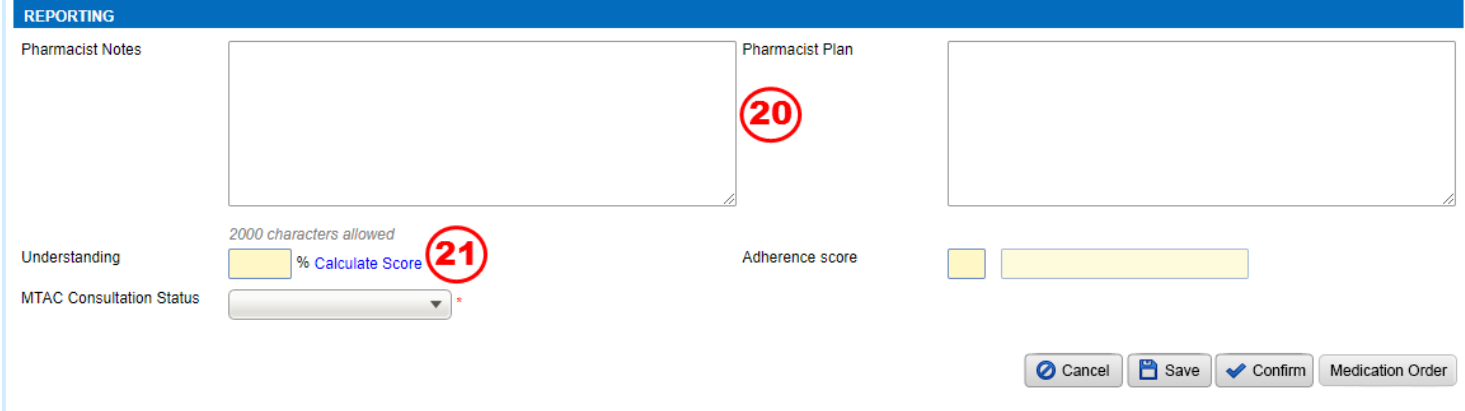


Figure 3.2.1-12 Information Alert Message

Note

- User will be able to close the record at reporting screen or continue with the reporting section.
- Click on the **Reporting** row (blue color) once and scroll down to continue with the reporting process.
- “Recommended Lab Test field” was removed and rearranged the Pharmacist Note and Remarks field.
- ‘Compliance Score’ was renamed to “Adherence Score”.



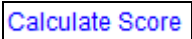
The image shows the MTAC Reporting form. It has a blue header labeled "REPORTING". The form is divided into two main sections: "Pharmacist Notes" and "Pharmacist Plan". The "Pharmacist Notes" section has a text area with a "2000 characters allowed" label and a "Calculate Score" button. A red circle with the number "21" is overlaid on the "Calculate Score" button. The "Pharmacist Plan" section has a text area. A red circle with the number "20" is overlaid on the "Pharmacist Plan" text area. Below these sections are "Understanding" and "Adherence score" fields, each with a yellow progress bar. The "Understanding" field also has a "Calculate Score" button. At the bottom, there is an "MTAC Consultation Status" dropdown menu. At the bottom right, there are four buttons: "Cancel", "Save", "Confirm", and "Medication Order".

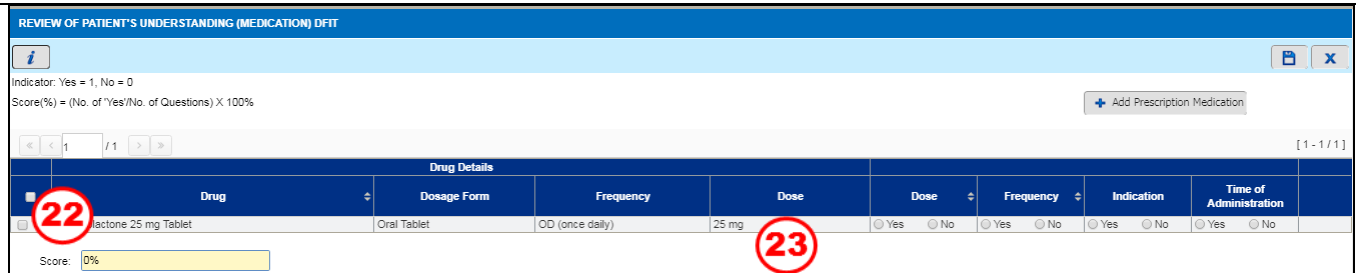
Figure 3.2.1-13 MTAC Reporting

STEP 20

Enter the **Pharmacist Notes** and **Pharmacist Plan**

STEP 21

Click on the  hyperlink for **Understanding** and the ‘**Review of Patient’s Understanding (Medication) DFIT**’ will be displayed as shown in Figure 3.2.1-14



Drug Details							
Drug	Dosage Form	Frequency	Dose	Dose	Frequency	Indication	Time of Administration
<input checked="" type="checkbox"/> Losartone 25 mg Tablet	Oral Tablet	OD (once daily)	25 mg	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

Figure 3.2.1-14 Review of Patient's Understanding (Medication) DFIT

STEP 22

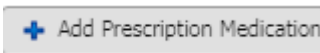
Click at the checkbox to select drug

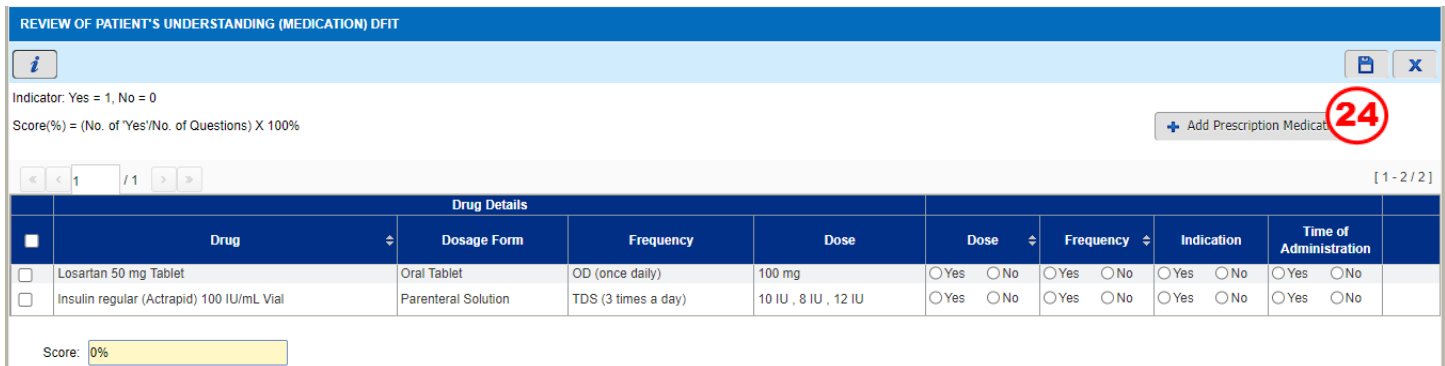
STEP 23

Select **Dose, Frequency, Indication and Time of Administration** from the radio button:

- Yes
- No

Note


- System will auto capture existing drugs ordered for patient in Drug details
- Score will be automatically calculated and displayed.
- User able to add additional drugs by clicking at  button to add new Prescription medication



Drug Details							
Drug	Dosage Form	Frequency	Dose	Dose	Frequency	Indication	Time of Administration
<input type="checkbox"/> Losartan 50 mg Tablet	Oral Tablet	OD (once daily)	100 mg	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/> Insulin regular (Actrapid) 100 IU/mL Vial	Parenteral Solution	TDS (3 times a day)	10 IU , 8 IU , 12 IU	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

Figure 3.2.1-15 Review of Patient's Understanding (Medication) DFIT

STEP 24

Click on the  button to save the Understanding calculator record

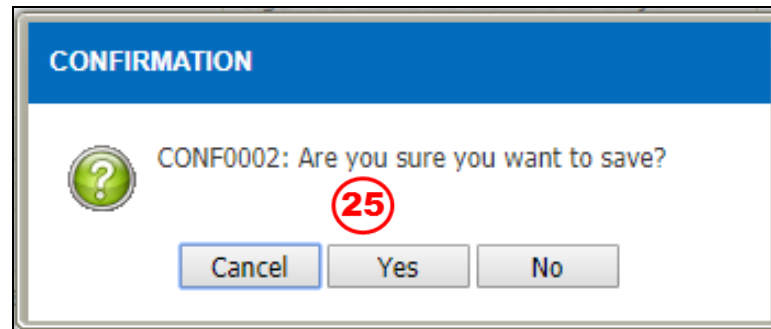


Figure 3.2.1-16 Confirmation alert message

STEP 25

Click on the  button to confirm save record

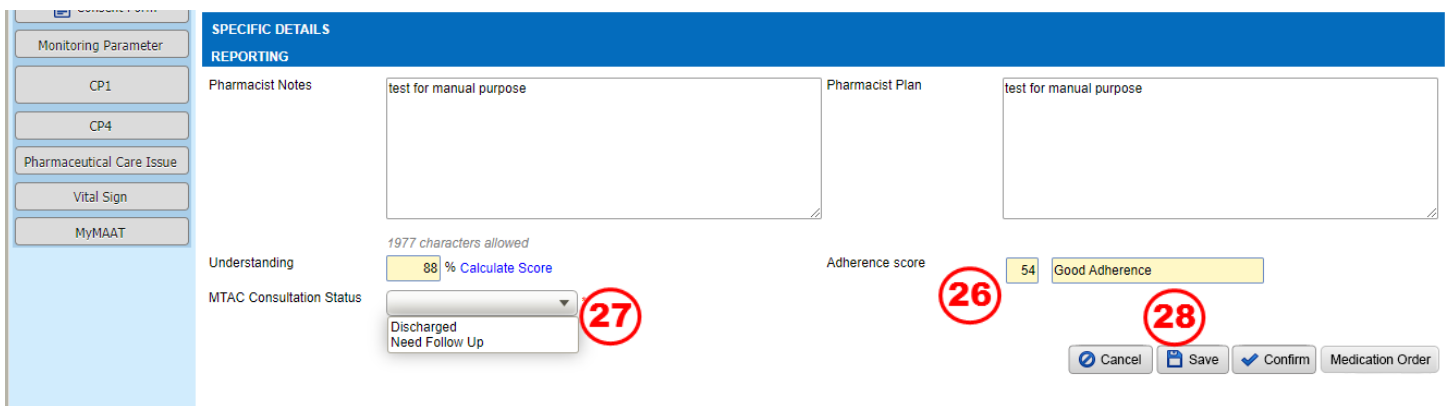


Figure 3.2.1-17 MTAC Reporting - Reporting

STEP 26


Adherence Score is captured from MyMAAT assessment results

STEP 27


Select **MTAC Consultation Status** from the drop-down box

- Discharged
- Need Follow Up

Note

- Medication Order button reallocate at the bottom of the screen.
- Click on the  button to view medication order screen and perform MTAC medication order if necessary.

STEP 28

Click on the  button as shown in Figure 3.2.1-17

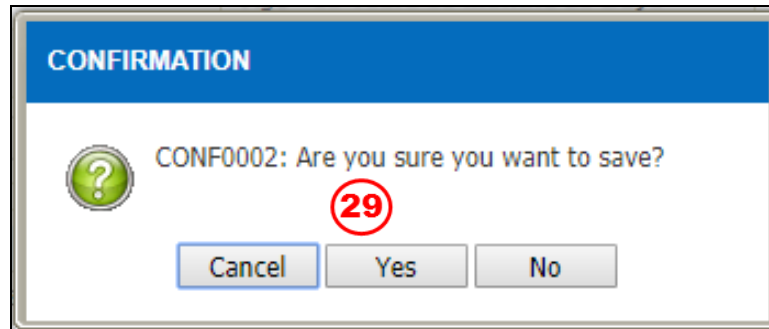


Figure 3.2.1-18 Confirmation Alert Message

STEP 29

Click on the  button to confirm save record

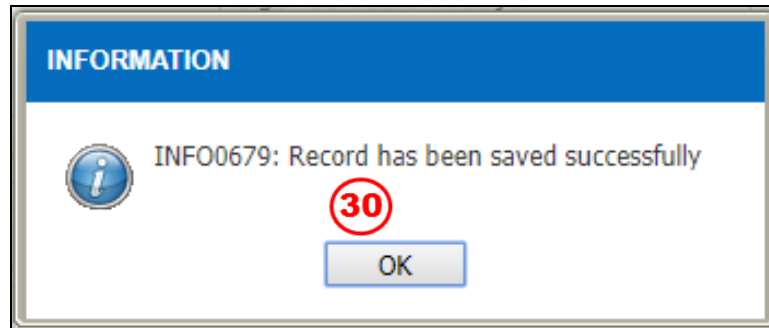



Figure 3.2.1-19 Information Alert Message

STEP 30

Click on the  button

Note

- User can cancel MTAC reporting by clicking at the  button as in Figure 3.2.1-17 and confirmation pop up will appear as shown in Figure 3.2.1-20

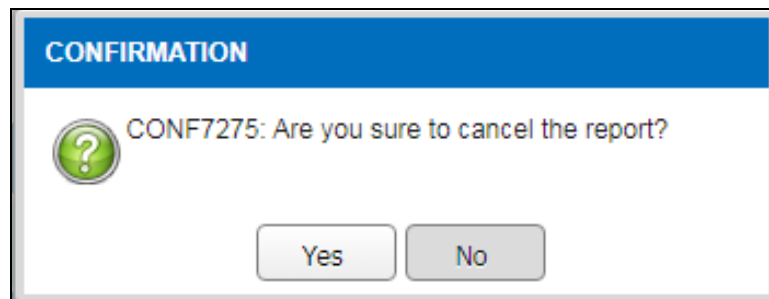


Figure 3.2.1-20 Confirmation Alert Message

- Click at  button to cancel MTAC Reporting

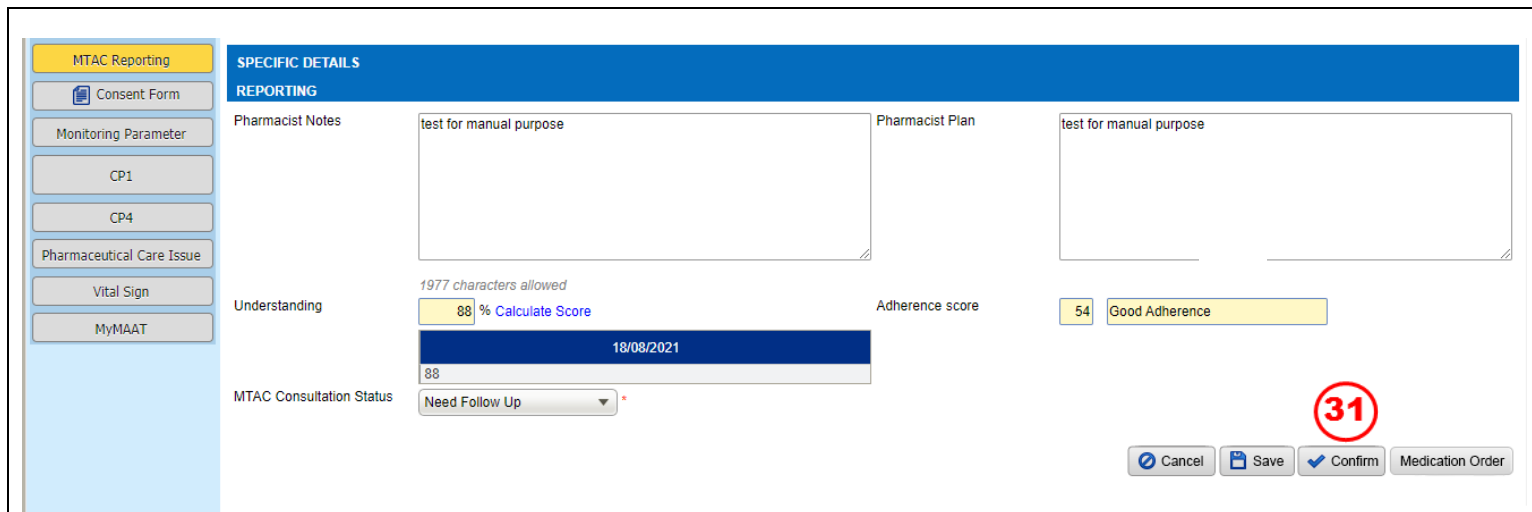



Figure 3.2.1-21 MTAC Reporting – Reporting

STEP 31

Click on the  button to confirm reporting

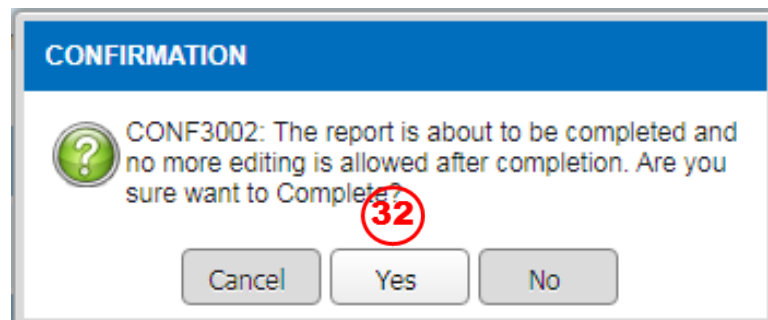


Figure 3.2.1-22 Confirmation Alert Message

STEP 32

Click on the  button to complete

Note

- After user has confirmed the record, no more editing is allowed, and the boxes change to yellow color.
- Previous Adherence Score record from previous visit is display (if any – max 5 newest record).

Encounter No: 0005 Actual Visit Date: 30/07/2021 Attending Practitioner: Visit Location: KLINIK PAKAR PEMBEDAHAN Prescriber Dept.:

Virtual Session: No

Type of MTAC: Diabetes Mellitus

Number of MTAC Visit: 1

MTAC No: MTA210004813

Understanding: 88% [Calculate Score](#)

Adherence score: 54 [Good Adherence](#)

MTAC Consultation Status: 18/08/2021

88

Need Follow Up [MTAC Order](#) **33**

Remarks: [Medication Order](#)

[Save](#)

Figure 3.2.1-23 MTAC Reporting Screen

STEP 33

Click on the [MTAC Order](#) button to schedule for next follow up appointment as per Figure 3.2.1-23 and MTAC order screen will display as per Figure 3.2.1-24

MTAC ORDER

[Proceed To Reporting](#)

Age: 21 Years 05 Months 17 Days Gender: Female MRN: HPSF00305673

Address Phone And Email Diagnosis **Known Allergies** Vital Sign

Height: 170 cm Weight: 60 kg BMI/BSA: 20.8 / 1.68 m² Update (Last Updated: 30/07/2021) Nationality: Warganegara

Type Of MTAC: Diabetes Mellitus [Search History](#)

Priority: Routine

To Be Counseled By:

Virtual Session: Yes No

Appointment Date: 19/08/2021 [Audit Trail](#)

Appointment Type: Follow Up **34**

Remarks:

MTAC HISTORY

MTAC No	Type of MTAC	Appointment Date	Appointment Type	Status	Updated By
MTA210004813	Diabetes Mellitus	18/08/2021	New	Completed	

Figure 3.2.1-24 MTAC Order Screen

STEP 34

Schedule the follow up in the MTAC Order screen and the follow up date will appear in the reporting screen as shown in Figure 3.2.1-25

Encounter No: 0005 Actual Visit Date: 30/07/2021 Attending Practitioner: Visit Location: KLINIK PAKAR PEMBEDAHAN Prescriber Dept.:

Virtual Session: : No Type of MTAC: Diabetes Mellitus Number of MTAC Visit: : 1 MTAC No: MTA210004813

Understanding: 88 % Adherence score: 54

1977 characters allowed

Date: 18/08/2021
Score: 88

MTAC Consultation Status: *

Follow Up Date: 19/08/2021

Remarks:

Figure 3.2.1-25 MTAC Reporting Screen

Note

User able to enter remarks after confirm / cancel MTAC Report and the remarks will appear in MTAC report printing

Encounter No: 0005 Actual Visit Date: 30/07/2021 Attending Practitioner: Visit Location: KLINIK PAKAR PEMBEDAHAN Prescriber Dept.:

Virtual Session: : No Type of MTAC: Diabetes Mellitus Number of MTAC Visit: : 1 MTAC No: MTA210004813

MTAC REPORTING

ASSESSMENT

SPECIFIC DETAILS

REPORTING

Pharmacist Notes: Pharmacist Plan:

Understanding: 88 % Adherence score: 54

1977 characters allowed


Date: 18/08/2021
Score: 88

MTAC Consultation Status: *

Follow Up Date: 19/08/2021

Figure 3.2.1-26 MTAC Reporting – Print

Note

- Click on the  button to print the MTAC report as per Figure 3.2.1-26 and the system will show the report as per Figure 3.2.1-27
- Default to "No history of taking Non-Prescription Medication" if no data in table (in printed report).
- Add "Prescriber Review" Column
- If there is no data in both table, please display as below:
 - No Prescribed Medication Related Issue
 - No Other Issue
- Show "Current Medication" in the report printing
- Add Intervention Date in PCI reporting screen for prescribed Medication issue.



MEDICATION THERAPY ADHERENCE REPORT

Hospital Pakar Sultanah Fatimah

Patient Name :	██████████	Diagnosis :	tonsilactomy, fever
MRN :	HPSF00305673	Allergy :	Diclofenac, seafood
ID No :	██████████	Number of MTAC Visit :	1
Type of MTAC :	Diabetes Mellitus	MTAC Visit Date :	18/08/2021

Assessment:

Social History		Family History						
Medical History	Comorbidity							
	Surgical History :- No							
	Diagnostic Test :- N/A							
Past Medication History	Medication (Specify Strength)	Order Detail	Start Date	End Date	Balance From	Medication Status	Comment	Remarks
	No history of taking Prescription Medication							
	Non-Prescription Medication (Includes Herbal/Vitamin/Other Supplement)				Reason For Taking	Balance/Comments		
	No history of taking Non-Prescription Medication							
Current Medication List	Drug	Drug Detail	Date Start	Date Stop	Order Location			
	Insulin regular (Actrapid) 100 IU/mL Vial	10 IU (08:00 AM), 8 IU (12:00 PM), 12 IU (08:00 PM), TDS (3 times a day)	29/07/2021 02:43:20 PM	27/09/2021 02:43:20 PM	KLINIK PAKAR PERUBATAN - MOPC			
	Losartan 50 mg Tablet	100 mg ,OD (once daily)	29/07/2021 02:55:23 PM	26/12/2021 02:55:23 PM	KLINIK PAKAR PERUBATAN - MOPC			

Report:

MTAC Consultation Status: Need Follow Up

Pharmaceutical Care Issues:

Prescribed Medication Related Issues:

No.	Intervention Date	Prescription Start Date	Original Rx No.	Drug Name	Order Details	Modified Order Details	Intervention Remarks	Intervention Details		Prescriber Review
								Types	Description	
No Prescribed Medication Related Issues										

Other Issue:

No.	Intervention Date	Intervention Details		Pharmaceutical Care Issues	Pharmacist Recommendation	Outcome	Follow-up	Prescriber Review
		Types	Description					
No Other Issue								

Patient Understanding (medication) DFIT : 88%

Patient Adherence Score : 54 - Good Adherence

Pharmacist Notes : test for manual purpose

Pharmacist Plan : test for manual purpose

Follow up Date : 19/08/2021

Remarks :

Pharmacist Name: ██████████

Date: 18/08/2021

Figure 3.2.1-27 MTAC Printed Report

3.2.2 Other Tabs

3.2.2-1 Monitoring Parameter

This function allows user to record lab results for MTAC patients.

Encounter No: 0005 Actual Visit Date: 30/07/2021 Attending Practitioner: Visit Location: KLINIK PAKAR PEMBEDAHAN Prescriber Dept:

Virtual Session: No Type of MTAC: Diabetes Mellitus Number of MTAC Visit: 1 MTAC No: MTA210004813

MONITORING PARAMETER

FBC BUSE/RP LFT Coag CE Urine FEME LP Blood Sugar ABG Thyroid RVD Hepatitis Drug Urine Test Others

Full Blood Count

Date/Time:

Result	Normal Range				
Sample	Result	Adult	Children	Neonates	Infant
TWBC	<input type="text"/> x10/L	4 - 11 x 10 ⁹	4.5-13.5	5-21	6-18
Neutrophils	<input type="text"/>	0.4-0.7	55	40	30
Lymphocytes	<input type="text"/>	0.22-0.44	38	63	48
Eosinophils	<input type="text"/>	0-0.08			
Basophils	<input type="text"/>	0-0.03			
RBC (/L)	<input type="text"/> x10 ⁶	4.5- 6.3 x 10 ¹²	3.7 - 6.5 x 10 ¹²	3.7 - 6.5 x 10 ¹²	
Monocytes	<input type="text"/>				
Hb (g/dL)	<input type="text"/> g/100ml	Male 13.5 - 17.5 Female 12 - 16			
HCT	<input type="text"/>	Male 0.41 - 0.53 Female 0.36 - 0.46	0.31 - 0.37	0.28 - 0.55	0.33 - 0.39

Remarks:

Figure 3.2.2-1 MTAC Reporting Screen

STEP 1

Click on the Monitoring Parameter button to enter Lab Test Result and the system will show Figure 3.2.2-2

MONITORING PARAMETER

FBC BUSE/RP LFT **Coag** CE Urine FEME LP Blood Sugar ABG Thyroid RVD Hepatitis Drug Urine Test Others

Coagulation Profile

Date/Time:

Result	Normal Range			
Sample	Result	Adult	Children	Neonates & Infant
PT (sec)	<input type="text"/>	10 - 13.5	11 - 15	10 - 13.5
APTT (sec)	<input type="text"/>	26 - 42	26 - 42	26 - 42
INR	<input type="text"/>	<1.5	<1.5	<1.5

Remarks:

Result List

< 1 / 1 >

Date/Time	PT (sec)	APTT (sec)	INR	Remarks
No Records Found!				

Figure 3.2.2-2 Monitoring Parameter Screen

STEP 2

Click on the Lab Test Tabs as per Figure 3.2.2-2

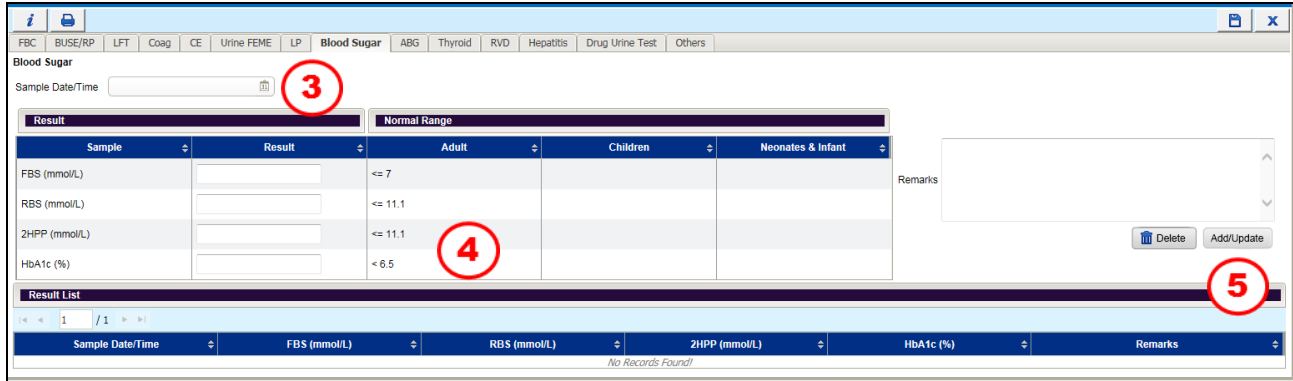



Figure 3.2.2-3 Monitoring Parameter Screen

STEP 3

Click on the  calendar button to select the **Sample Date/Time**

STEP 4

Enter the Lab Test **Result** and **Remarks**

STEP 5

Click the  button and **Result List** will be updated as per Figure 3.2.2-4

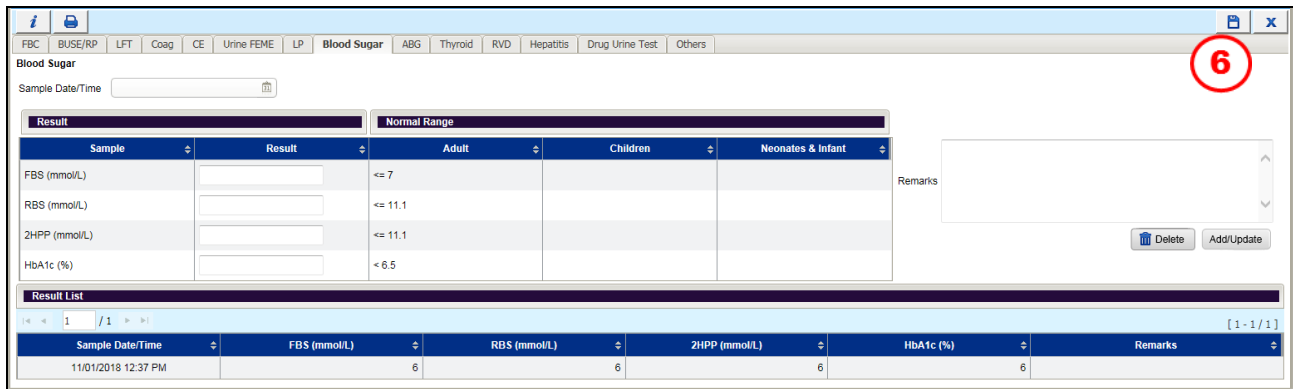


Figure 3.2.2-4 Monitoring Parameter Screen

STEP 6

Click on the  button to save the record

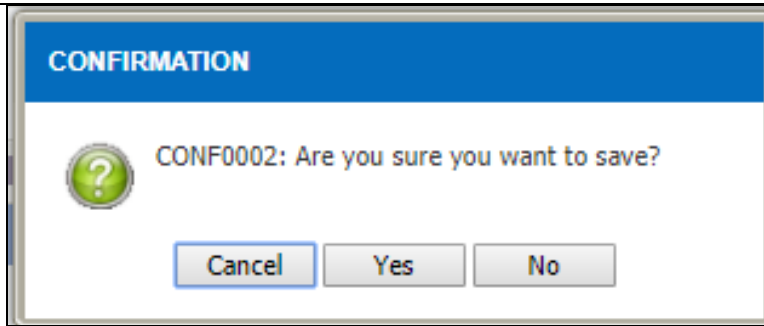
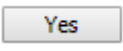


Figure 3.2.2-5 Confirmation Alert Message

STEP 7

Click on the  button to confirm

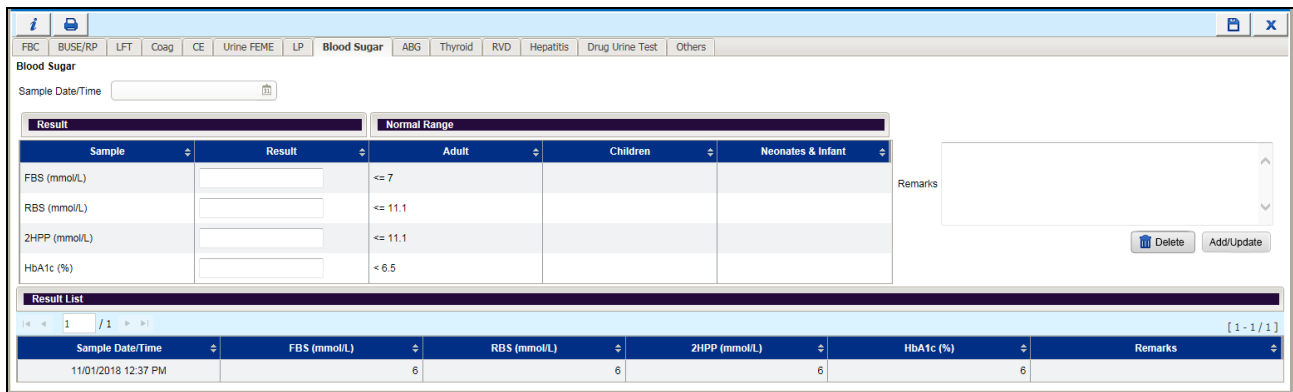




Figure 3.2.2-6 Monitoring Parameter Screen

Note

- To delete the record, double click the Result List and click the  button.
- To print the lab report, click on the  button as per Figure 3.2.2-6

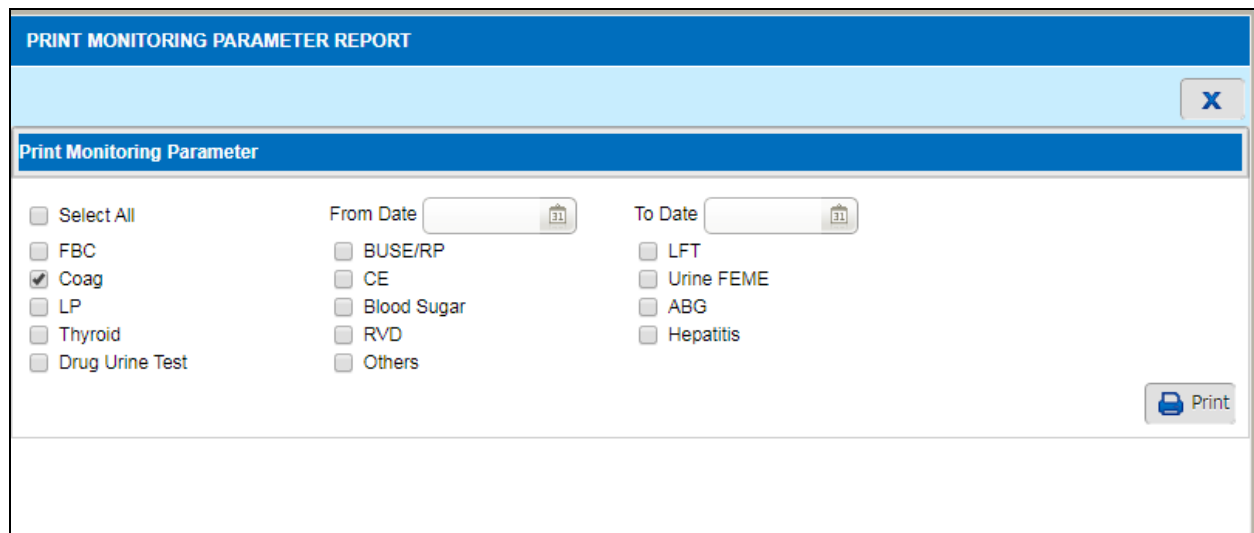




Figure 3.2.2-7 Print Monitoring Parameter Report

- Tick the checkbox to select the **Lab Test** and Select **From Date & To Date** by clicking the  button.
- Click the  **Print** button to print the Monitoring Parameter Report as per Figure 3.2.2-7

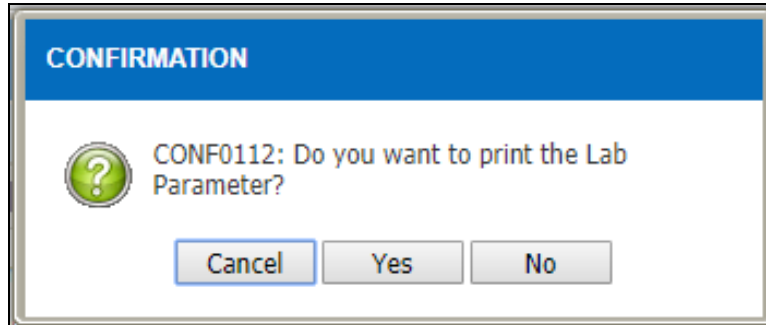
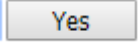
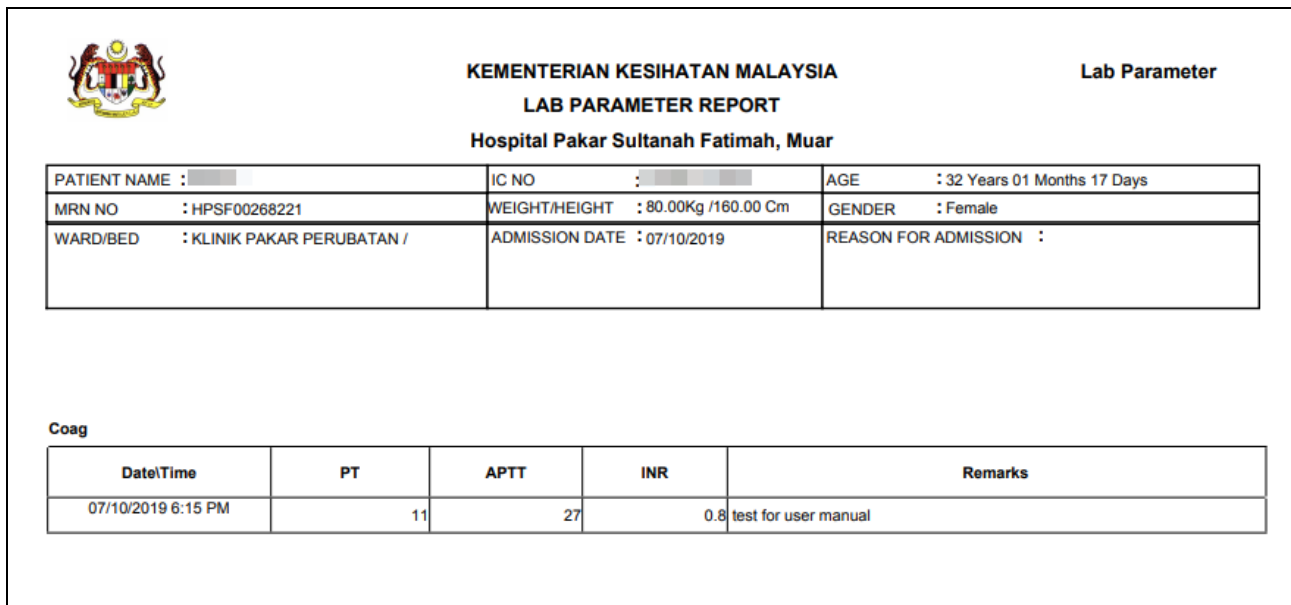


Figure 3.2.2-8 Confirmation Alert Message

- Click the  **Yes** button to confirm and the system will show the Monitoring Parameter Report as per Figure 3.2.2-9



The image shows a printed report header and a table. The header includes the Ministry of Health Malaysia logo, the text "KEMENTERIAN KESIHATAN MALAYSIA", "LAB PARAMETER REPORT", "Hospital Pakar Sultanah Fatimah, Muar", and "Lab Parameter".

PATIENT NAME : <input type="text"/>	IC NO : <input type="text"/>	AGE : 32 Years 01 Months 17 Days
MRN NO : HPSF00268221	WEIGHT/HEIGHT : 80.00Kg /160.00 Cm	GENDER : Female
WARD/BED : KLINIK PAKAR PERUBATAN /	ADMISSION DATE : 07/10/2019	REASON FOR ADMISSION :

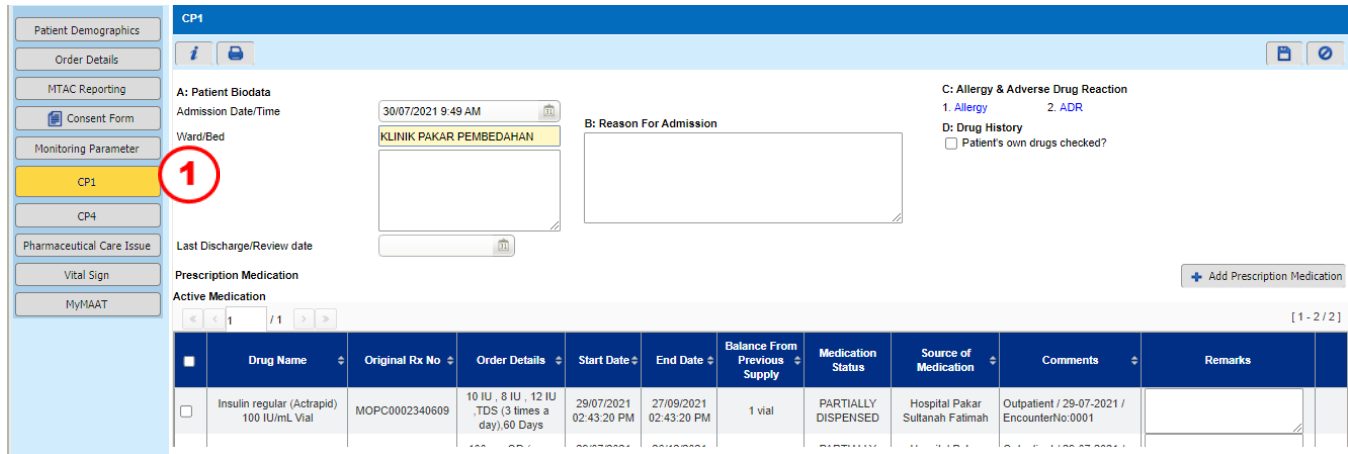
Coag

Date\Time	PT	APTT	INR	Remarks
07/10/2019 6:15 PM	11	27	0.8	test for user manual

Figure 3.2.2-9 Monitoring Parameter Printed Report

3.2.2.2 CP1

This function allows user to record past medication history under CP1 for MTAC patients

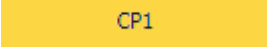


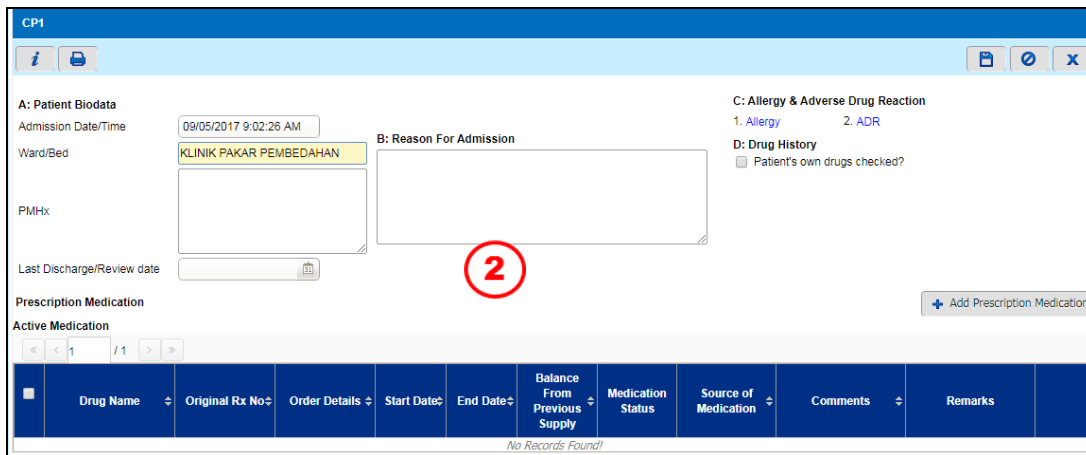
The screenshot shows the CP1 form interface. On the left, a navigation menu includes buttons for Patient Demographics, Order Details, MTAC Reporting, Consent Form, Monitoring Parameter, CP1 (highlighted with a red circle and '1'), CP4, Pharmaceutical Care Issue, Vital Sign, and HyMAAT. The main form area contains sections for Patient Biodata (Admission Date/Time: 30/07/2021 9:49 AM, Ward/Bed: KLINIK PAKAR PEMBEDAHAN), Reason For Admission, Allergy & Adverse Drug Reaction (1. Allergy, 2. ADR), Drug History (Patient's own drugs checked?), and Prescription Medication. Below these sections is a table of active medication with the following data:

Drug Name	Original Rx No	Order Details	Start Date	End Date	Balance From Previous Supply	Medication Status	Source of Medication	Comments	Remarks
Insulin regular (Actrapid) 100 IU/mL Vial	MOPC0002340609	10 IU, 8 IU, 12 IU, TDS (3 times a day), 60 Days	29/07/2021 02:43:20 PM	27/09/2021 02:43:20 PM	1 vial	PARTIALLY DISPENSED	Hospital Pakar Sultanah Fatimah	Outpatient / 29-07-2021 / EncounterNo:0001	

Figure 3.2.2.2-1 MTAC Reporting – Assessment on Past Medication History

STEP 1

Click on the  button to add 'Past Medication History' as shown in Figure 3.2.2.2-1



The screenshot shows the CP1 form with the following details filled in: Admission Date/Time: 09/05/2017 9:02:26 AM, Ward/Bed: KLINIK PAKAR PEMBEDAHAN, and Reason For Admission. A red circle with the number '2' highlights the Reason For Admission text area. The Prescription Medication section shows 'No Records Found!'.

Figure 3.2.2.2-2 CP1

STEP 2

Fill in the patients details as below:

-A: Patient Biodata

- Admission date
- Ward/Bed
- PMHX
- Last Discharge/review Date

-B: Reason For Admission


-C: Allergy & Adverse Drug Reaction

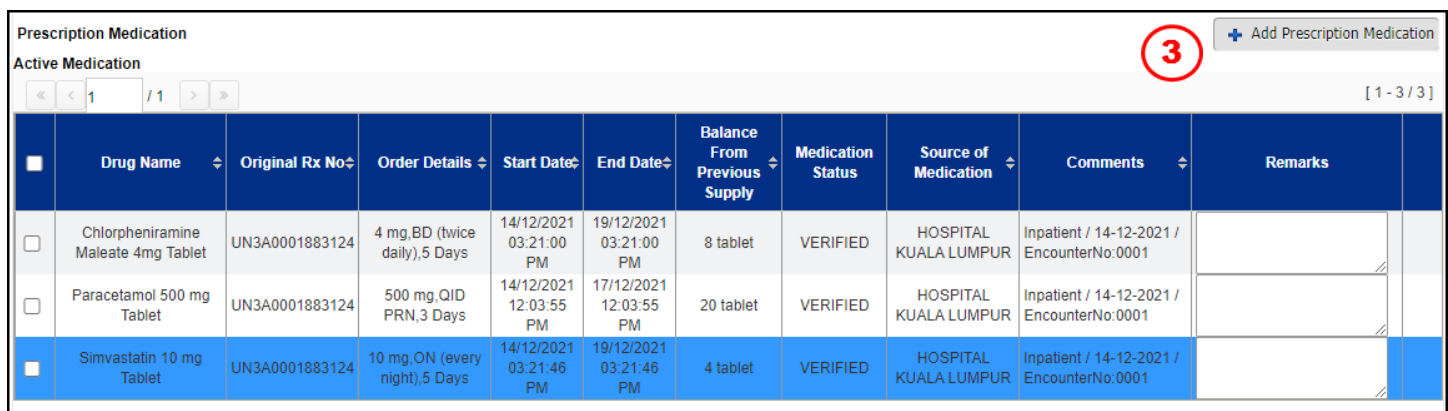
- Allergy
- ADR

-D: Drug History

- Patients own drug checked?

STEP 3

Click on the  button and the 'Prescription Medication' window will be displayed as shown in Figure 3.2.2.2-3. Enter the necessary information and save



<input type="checkbox"/>	Drug Name	Original Rx No	Order Details	Start Date	End Date	Balance From Previous Supply	Medication Status	Source of Medication	Comments	Remarks
<input type="checkbox"/>	Chlorpheniramine Maleate 4mg Tablet	UN3A0001883124	4 mg, BD (twice daily), 5 Days	14/12/2021 03:21:00 PM	19/12/2021 03:21:00 PM	8 tablet	VERIFIED	HOSPITAL KUALA LUMPUR	Inpatient / 14-12-2021 / EncounterNo:0001	
<input type="checkbox"/>	Paracetamol 500 mg Tablet	UN3A0001883124	500 mg, QID PRN, 3 Days	14/12/2021 12:03:55 PM	17/12/2021 12:03:55 PM	20 tablet	VERIFIED	HOSPITAL KUALA LUMPUR	Inpatient / 14-12-2021 / EncounterNo:0001	
<input checked="" type="checkbox"/>	Simvastatin 10 mg Tablet	UN3A0001883124	10 mg, ON (every night), 5 Days	14/12/2021 03:21:46 PM	19/12/2021 03:21:46 PM	4 tablet	VERIFIED	HOSPITAL KUALA LUMPUR	Inpatient / 14-12-2021 / EncounterNo:0001	

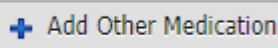
Figure 3.2.2.2-3 Add Prescription Medication

Note

Past Medication History:

- Prescription Medication.
 - It has certain condition whereby the drug display at prescription medication come from the latest visit patient at that facility
 - User can add prescriptions medication from other facility too
 - User can fill up **Original Rx No, Order Details, Start Date, End date, Balance from Previous Supply, Medication Status, Source of Medication, Comments and Remarks** at prescription medication

STEP 4

Click on the  button and the 'Other Medication' window will be displayed as shown in Figure 3.2.2.2-4. Enter the necessary information and save

Note

Past Medication History:

- Other Medication.
 - User can add any other medication that has been taken by patient in system
 - User can fill up **Other Medication(Includes Herbal/Vitamin/Other Supplement), Reason For Taking, Source of Medication, Balance/Comments and Pharmacist Notes** at the Other Medication field.

Other Medication

4 + Add Other Medication [1 - 2 / 2]

<input type="checkbox"/>	Other Medication (Includes Herbal/Vitamin/Other Supplements)	Reason For Taking	Source of Medication	Balance/Comments	
<input checked="" type="checkbox"/>	revicon forte	supplement	retail	100 tablets	
<input checked="" type="checkbox"/>					

Pharmacist Notes

Figure 3.2.2.2-4 Non-Prescription Medication

CP1

5

A: Patient Biodata
 Admission Date/Time: 08/12/2021 3:29 PM
 Ward/Bed: Farmasi Klinik Pakar/
 PMHx:
 Last Discharge/Review date:

B: Reason For Admission

C: Allergy & Adverse Drug Reaction
 1. Allergy 2. ADR

D: Drug History
 Patient's own drugs checked?


Prescription Medication + Add Prescription Medication

Active Medication [1 - 3 / 3]

<input type="checkbox"/>	Drug Name	Original Rx No	Order Details	Start Date	End Date	Balance From Previous Supply	Medication Status	Source of Medication	Comments	Remarks
<input type="checkbox"/>	Chlorpheniramine Maleate 4mg Tablet	UN3A0001883124	4 mg, BD (twice daily), 5 Days	14/12/2021 03:21:00	19/12/2021 03:21:00	8 tablet	VERIFIED	HOSPITAL KUALA LUMPUR	Inpatient / 14-12-2021 / EncounterNo:0001	

Figure 3.2.2.2-5 CP1 Screen

STEP 5

Click at the  button to save the CP1 record

3.2.2.3 CP4

This function allows user to record Intervention and other issues related to CP4 for MTAC patients

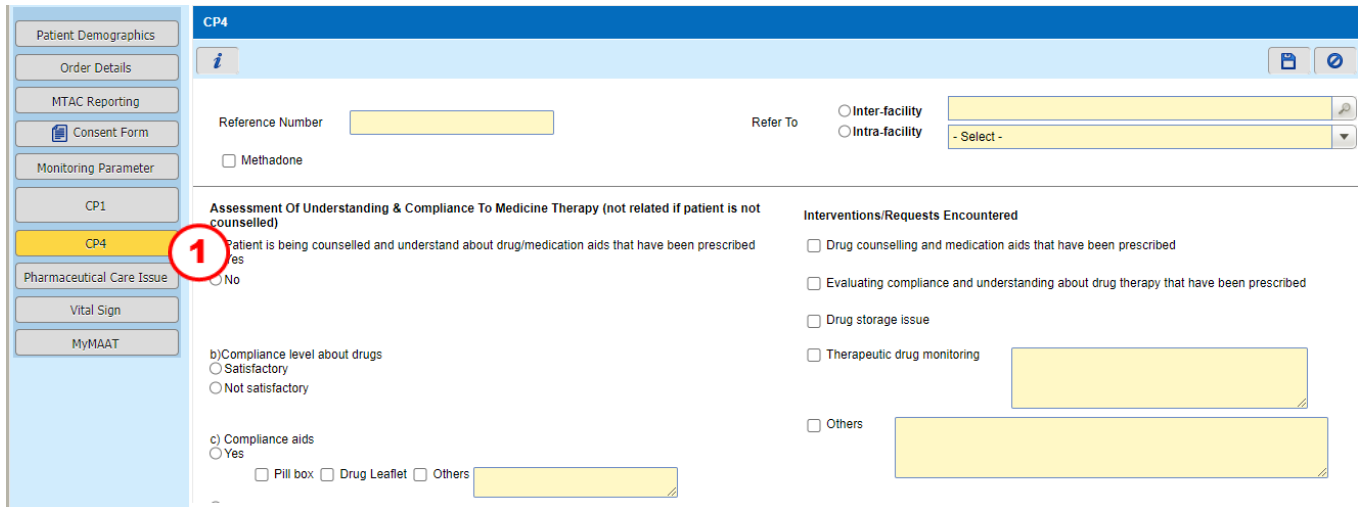


Figure 3.2.2.3-1 CP4 Screen

STEP 1

Click on the  button to enter the details

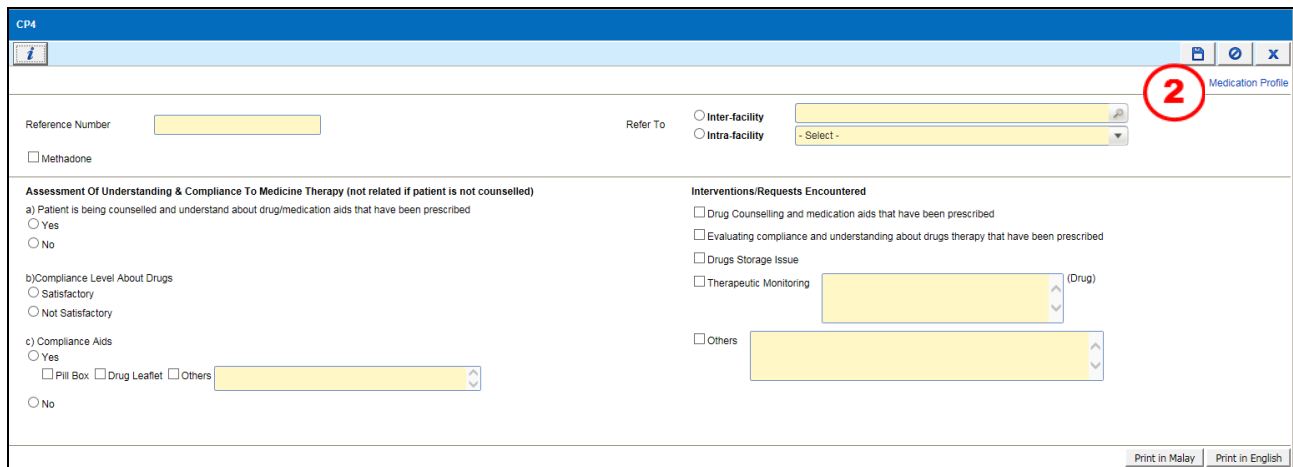


Figure 3.2.2.3-2 CP4 Assessment Of Understanding & Compliance Screen

Note

- For Methadone, user can click on the Methadone checkbox **Methadone** to assess the compliance as per Figure or proceed with the **Assessment Of Understanding & Compliance To Medicine Therapy** below and enter the **Interventions/Requests Encountered**

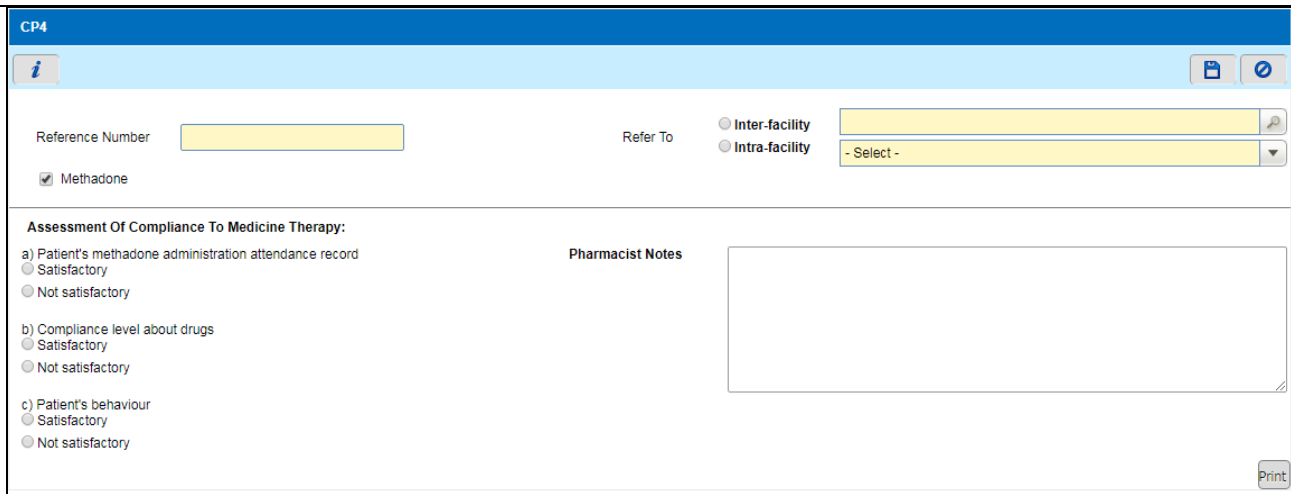


Figure 3.2.2.3-3 CP4 – Methadone Screen

STEP 2

Click on the  button to save the record

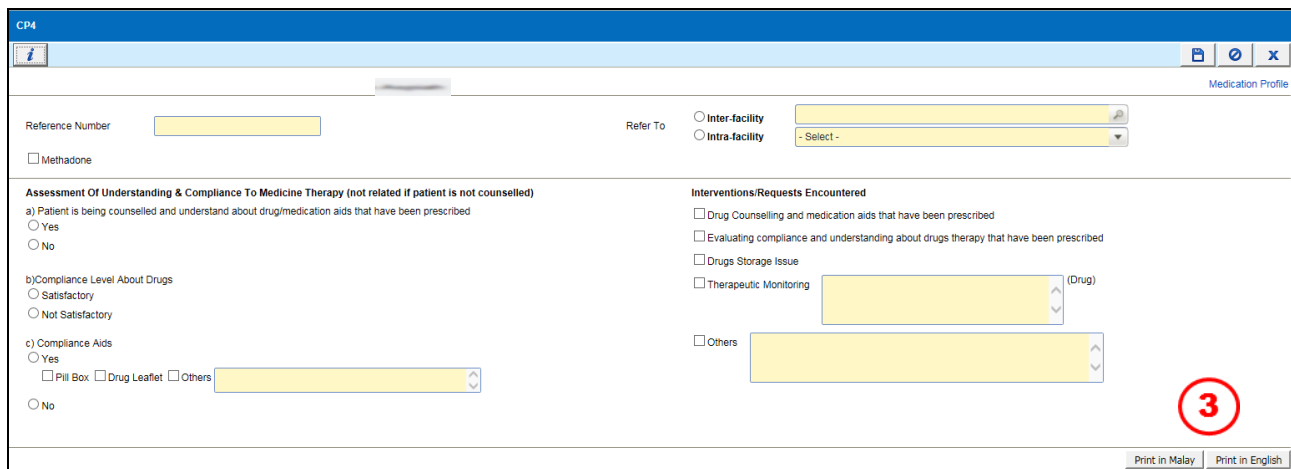
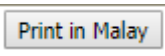
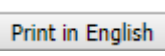


Figure 3.2.2.3-4 CP4 Print Report

STEP 3

Click on the  or  to print the CP4 as per Figure 3.2.2.3-4

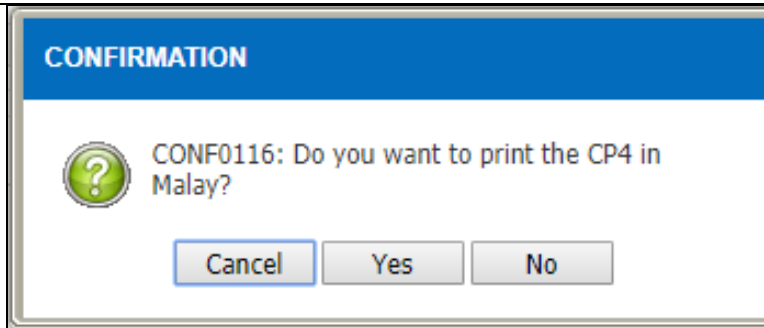


Figure 3.2.2.3-5 Confirmation Alert Message

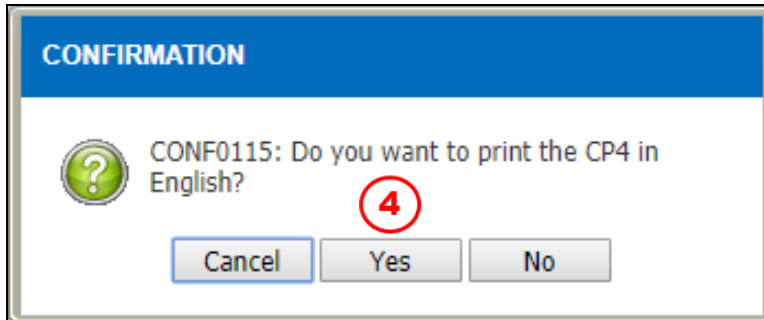


Figure 3.2.2.3-6 Confirmation Alert Message

STEP 4

Click on the  button to confirm and the Referral Note will be display as per Figure 3.2.2.3-7

KEMENTERIAN KESIHATAN MALAYSIA

Hospital Pakar Sultanah Fatimah

Pharmacy Department

REFERRAL NOTE

CP4/1601

TO:

Medical Officer / Pharmacist : Hospital Sultanah Nora Ismail

RE: PATIENT REFERRAL

_____ / **HPSF00305673** / _____
Name MRN IC No

This patient HAS / NOT-BEEN GIVEN MEDICATION COUNSELING for understanding of the treatment that have been prescribed. We expect that you can give the counselling & further evaluation that needed to increase the effectiveness of the treatment.

2. DIAGNOSIS :

Date	Diagnosis Description
30/07/2021	tonsilactomy

3. LIST OF CURRENT DRUG :

Drug Name	Dose	Frequency	Start Date	End Date	Supply Period
Losartan 50 mg Tablet	100 mg	OD (once daily)	29/07/2021	26/12/2021	5 Months
Insulin regular (Actrapid) 100 IU/mL Vial	10 IU , 8 IU , 12 IU	TDS (3 times a day)	29/07/2021	27/09/2021	60 Days

4. UNDERSTANDING ASSESSMENT & COMPLIANCE TO DRUG

(not applicable if the patient has not been counseled):

- a) The patient has been counseled and understand the drug/medication aids prescribed Yes No
- b) Compliance level about Drugs Satisfactory Not-
- c) Compliance Pill Box Drug Leaflet Others No

5. INFORMATION / REQUESTS ENCOUNTERED :

[Please tick () In the box provided]

<input checked="" type="checkbox"/>	Drug counselling and medication aids that have been prescribed
<input type="checkbox"/>	Evaluate compliance with and understanding of the prescribed drug therapy
<input type="checkbox"/>	Therapeutic drug monitoring:
<input type="checkbox"/>	Drug storage issues
<input checked="" type="checkbox"/>	Other: test for manual

Thank You,

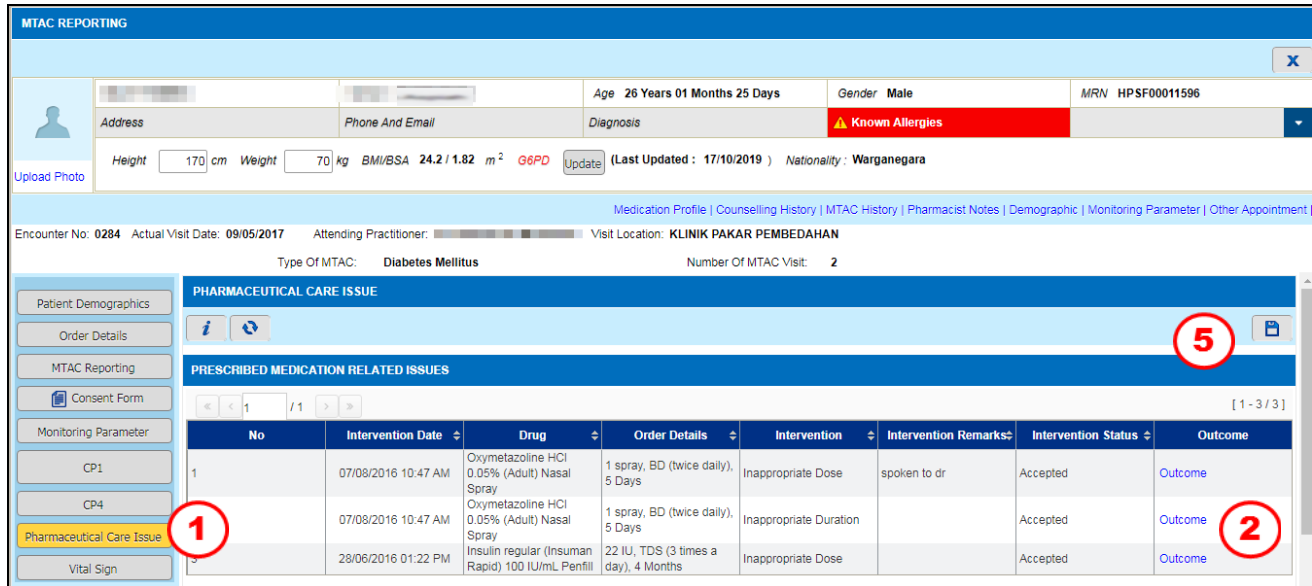
PFK

069521901

Figure 3.2.2.3-7 CP4 / Referral Note Printed Report

3.2.2.4 Pharmaceutical Care Issue

This function allows user to record pharmaceutical care issues for MTAC patients



MTAC REPORTING

Age 26 Years 01 Months 25 Days | Gender Male | MRN HPSF00011596

Diagnosis: **Known Allergies**

Height 170 cm | Weight 70 kg | BMI/BSA 24.2 / 1.82 m² | O6PD | (Last Updated: 17/10/2019) | Nationality: Warganegara

Encounter No: 0284 | Actual Visit Date: 09/05/2017 | Attending Practitioner: | Visit Location: KLINIK PAKAR PEMBEDAHAN

Type Of MTAC: Diabetes Mellitus | Number Of MTAC Visit: 2

PHARMACEUTICAL CARE ISSUE

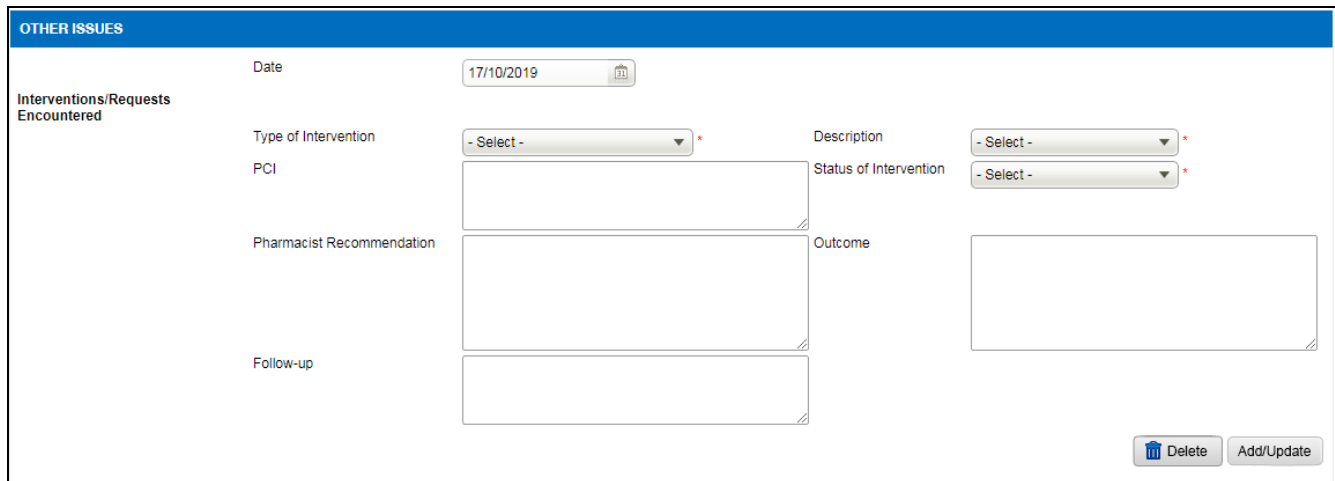
PRESCRIBED MEDICATION RELATED ISSUES

No	Intervention Date	Drug	Order Details	Intervention	Intervention Remarks	Intervention Status	Outcome
1	07/08/2016 10:47 AM	Oxymetazoline HCl 0.05% (Adult) Nasal Spray	1 spray, BD (twice daily), 5 Days	Inappropriate Dose	spoken to dr	Accepted	Outcome
	07/08/2016 10:47 AM	Oxymetazoline HCl 0.05% (Adult) Nasal Spray	1 spray, BD (twice daily), 5 Days	Inappropriate Duration		Accepted	Outcome
	28/06/2016 01:22 PM	Insulin regular (Insuman Rapid) 100 IU/mL Penfill	22 IU, TDS (3 times a day), 4 Months	Inappropriate Dose		Accepted	Outcome

Figure 3.2.2.4-1 MTAC Reporting Screen

STEP 1

Click on the **Pharmaceutical Care Issue** button and the system will display Prescribed Medication related Issues as in Figure 3.2.2.4-1 and Other issues as per Figure 3.2.2.4-2



OTHER ISSUES

Date: 17/10/2019

Interventions/Requests Encountered

Type of Intervention: - Select -

Description: - Select -

PCI: [Text Area]

Status of Intervention: - Select -

Pharmacist Recommendation: [Text Area]

Outcome: [Text Area]

Follow-up: [Text Area]

Buttons: Delete, Add/Update

Figure 3.2.2.4-2 Other Issues

Note

- The column for **Intervention Remarks** in PCI screen has been added.
- **Other Details** was renamed to **Order Details** as per Figure 3.2.2.4-1

STEP 2

Click on the [Outcome](#) hyperlink to enter the details. The system will display as per Figure 3.2.2.4-3. Save when done.

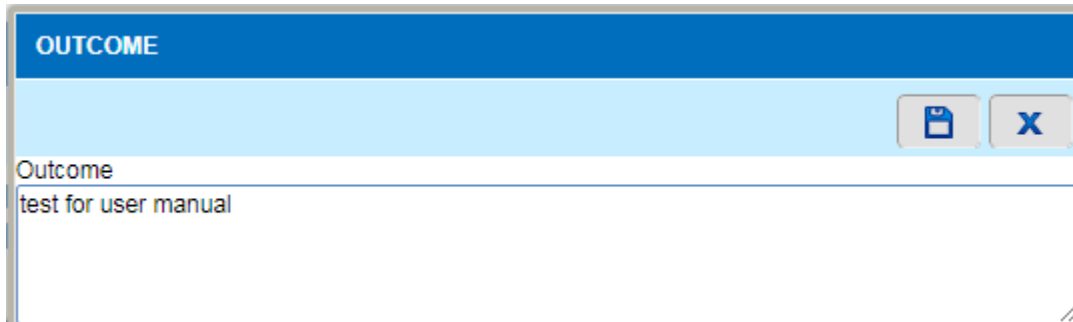


Figure 3.2.2.4-3 Outcome Screen

STEP 3

Fill up the **Interventions/Requests Encountered** under **Other Issues** section as per Figure 3.2.2.4-4

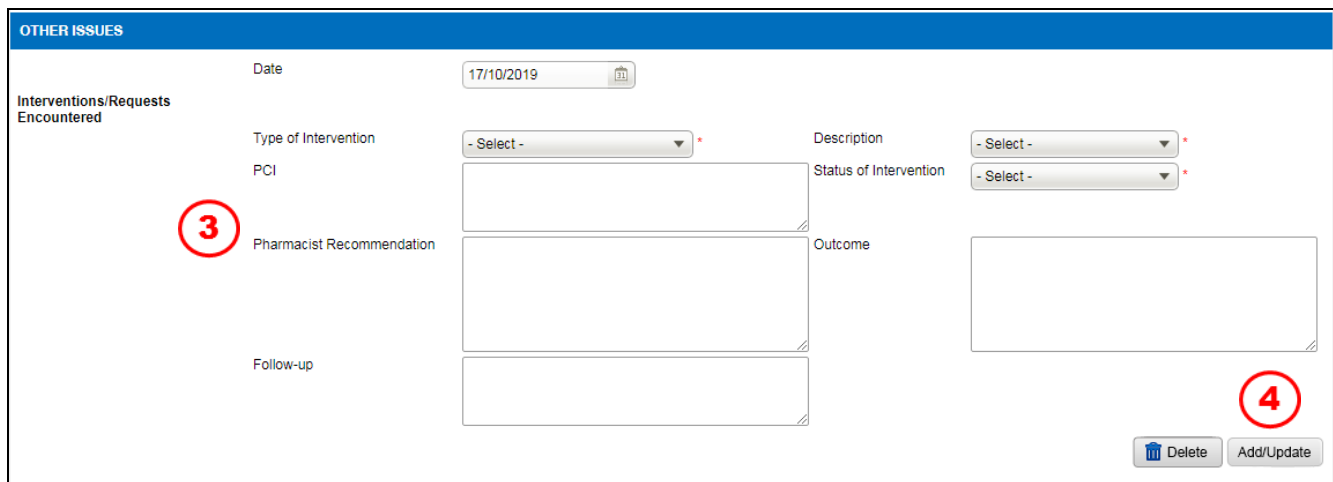
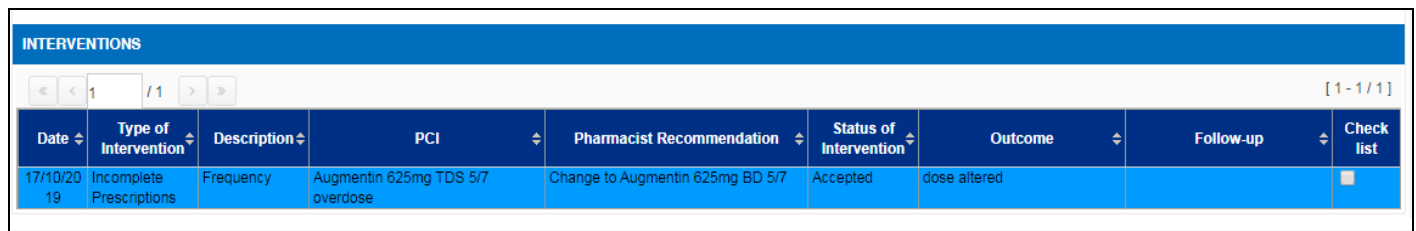


Figure 3.2.2.4-4 Other Issues Screen

STEP 4

Click on the [Add/Update](#) button to update and it will appear below under **Interventions** section as per Figure 3.2.2.4-5




Date	Type of Intervention	Description	PCI	Pharmacist Recommendation	Status of Intervention	Outcome	Follow-up	Check list
17/10/2019	Incomplete Prescriptions	Frequency	Augmentin 625mg TDS 5/7 overdose	Change to Augmentin 625mg BD 5/7	Accepted	dose altered		<input type="checkbox"/>

Figure 3.2.2.4-5 Interventions Section

Note

Tick on the  checkbox and click the  button to delete the intervention record as per Figure 3.2.2.4-5

STEP 5

Click on the  button to save the record as per Figure 3.2.2.4-1

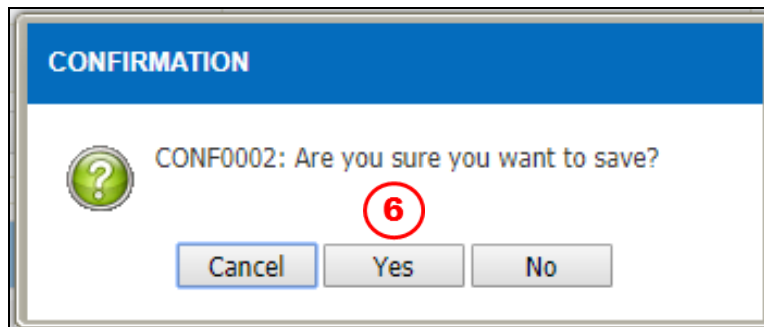
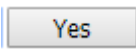


Figure 3.2.2.4-6 Confirmation Alert Message

STEP 6

Click on the  button to confirm

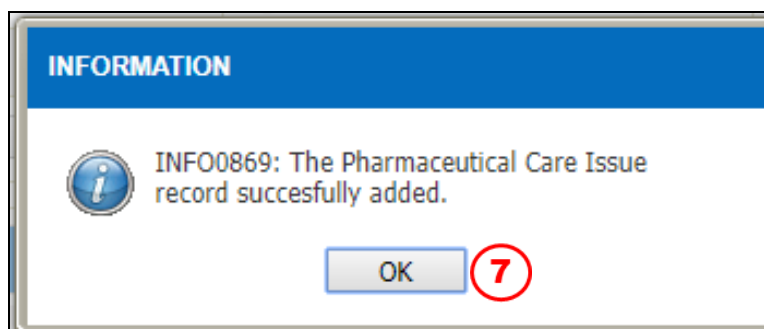


Figure 3.2.2.4.7 Information Alert Message

STEP 7

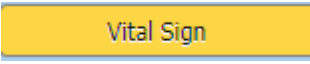
Click on the  button to successfully add PCI

3.2.2.5 Vital Signs


This function allows user to record vital signs for MTAC patients

Figure 3.2.2.5-1 MTAC Reporting Screen

STEP 1

Click on the  button to enter vital sign

STEP 2

Click on the  calendar button to select the **Date/Time**

STEP 3

Enter the Vital Sign **Result** and **Remarks**

Figure 3.2.2.5-2 Vital Sign Screen

STEP 4

Click the  button and **Result List** will be updated as per Figure 3.2.2.5-2

VITAL SIGN

5

Date/Time

Result	Normal Range		
Vital Sign	Result	Adult	Children
SBP (mmHg)	<input type="text"/>	120	95 - 105
DBP (mmHg)	<input type="text"/>	80	53 - 66
Temp (°C)	<input type="text"/>	37	36.5 - 37
PR (Pulse/min)	<input type="text"/>	60 - 100	60 - 140
RR (Breaths/min)	<input type="text"/>	12 - 18	18 - 30
Pain Score	<input type="text"/>	0 - 10	0 - 10

Remarks

Delete Add/Update

Result List

<< 1 / 1 >> [1 - 1 / 1]

Date/Time	SBP	DBP	Temp	PR	RR	Pain Score	Remarks
18/08/2021 08:33 PM	120	80	37	70	14	0	Patient is stable

Figure 3.2.2.5-3 Monitoring Parameter Screen

STEP 5

Click on the button to save the record

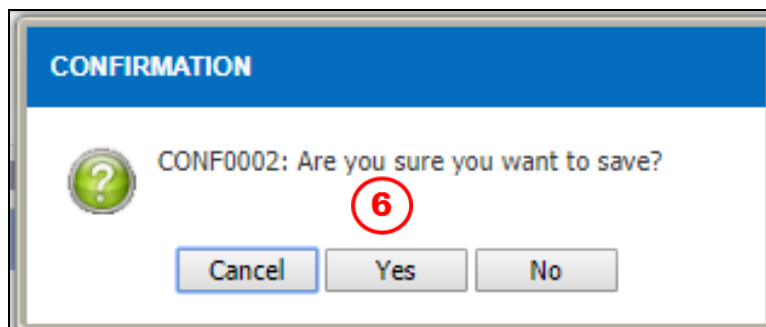


Figure 3.2.2.5-4 Confirmation Alert Message

STEP 6

Click on the Yes button to confirm

Note

To delete the record, double click the Result List and click the button.

3.2.2.6 MyMAAT

This function allows user to record adherence level of patients based on provided assessment

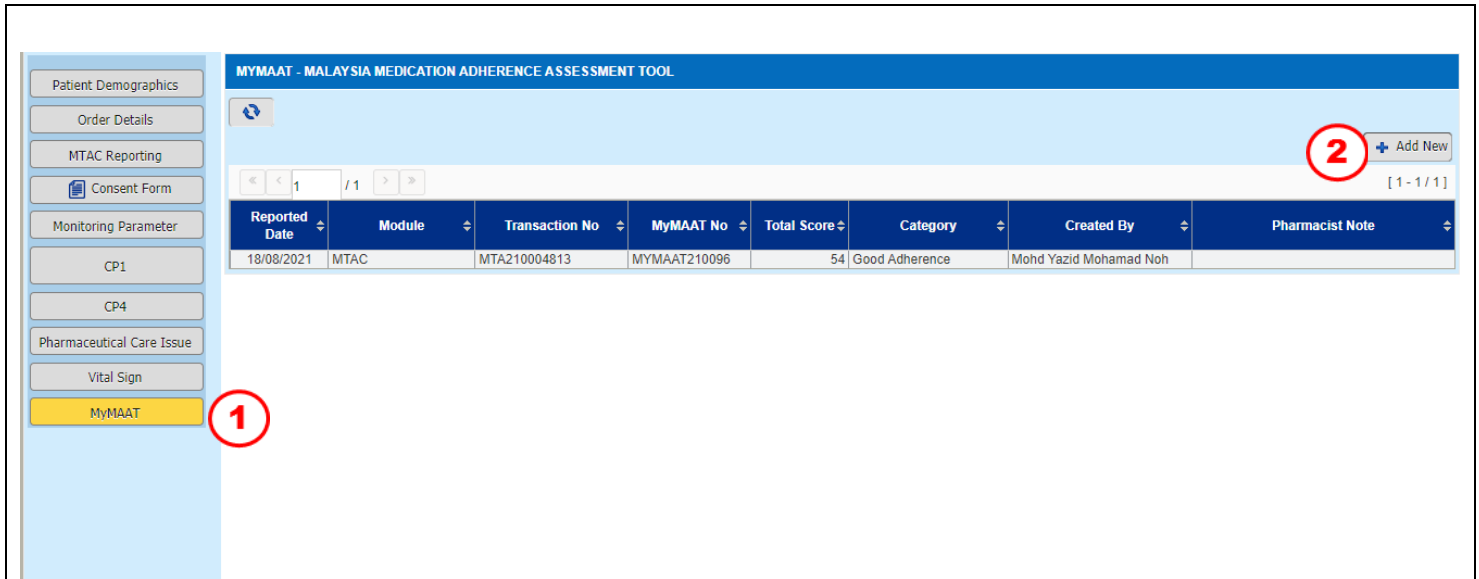


Figure 3.2.2.6-1 MTAC Reporting Screen

STEP 1

Click on the **MyMAAT** button to enter MyMAAT screen

STEP 2

Click on the **+ Add New** button to add new record and system will display as per Figure 3.2.2.6-2

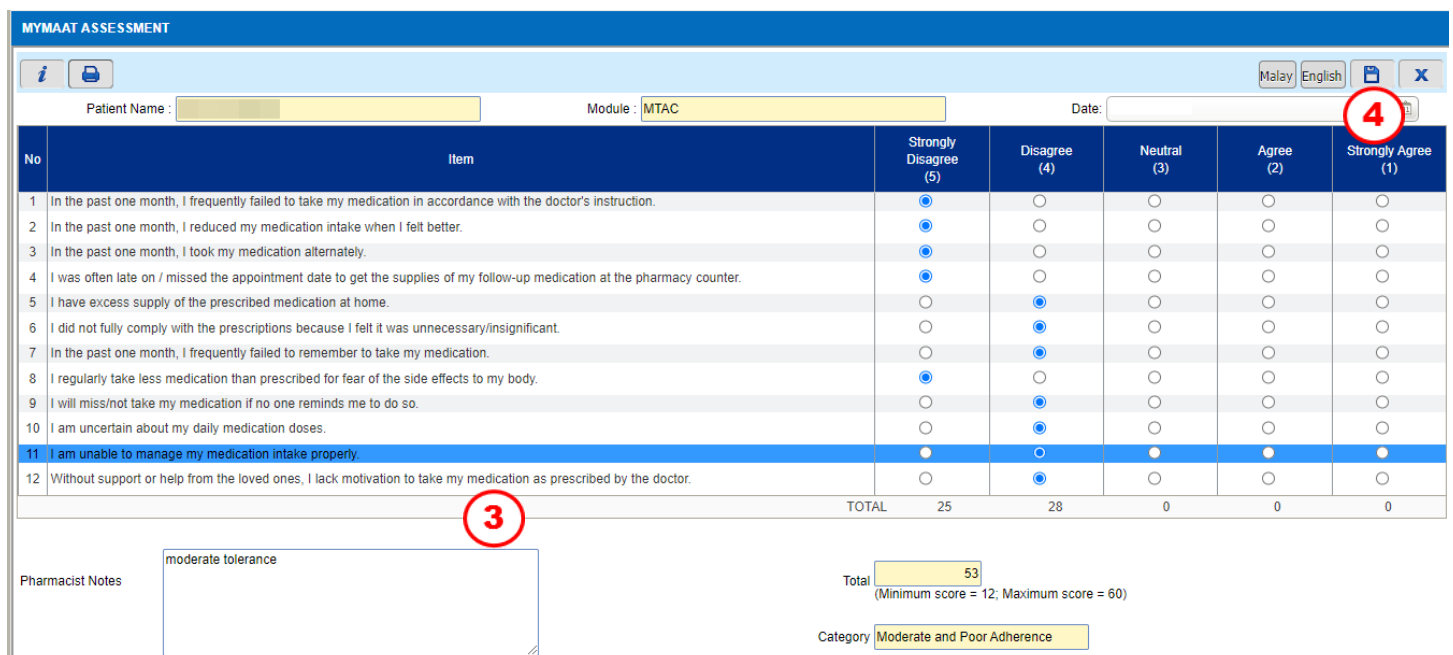


Figure 3.2.2.6-2 MYMAAT Assessment Screen

STEP 3

Fill up the assessment and **Pharmacist Notes** and system will generate the **Total score** and **Category**

STEP 4

Click on the  button to save the record

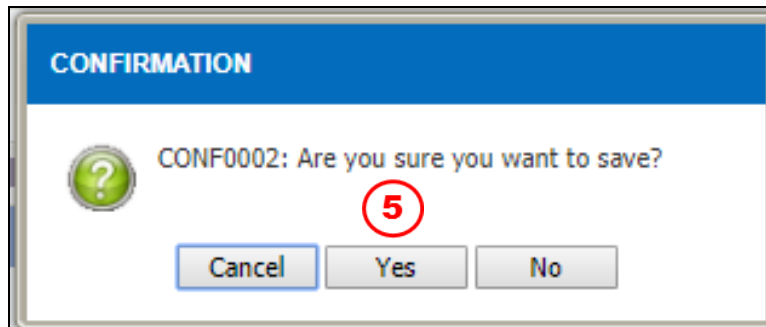
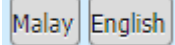



Figure 3.2.2.6-3 Confirmation Alert Message

STEP 5

Click on the  button to confirm

Note

- Click at  button to view assessment in Malay Language or English language as per Figure 3.2.2.6-2
- Click on the  button to print as per Figure 3.2.2.6-2 and system will display Bahagian 1 and Bahagian 2 as per Figure 3.2.2.6-4 and Figure 3.2.2.6-5



KEMENTERIAN KESIHATAN MALAYSIA

Hospital Pakar Sultanah Fatimah

**ALAT PENGUKURAN TAHAP KEPATUHAN PESAKIT TERHADAP PENGAMBILAN UBAT DI MALAYSIA
(MyMAAT)**

Nama Pesakit		MRN	HPSF00002944
		Tarikh	18/08/2021
No Kad Pengenalan		Lokasi	KLINIK PAKAR PERUBATAN

Bahagian I: Persepsi Tahap Kepatuhan Pesakit Terhadap Pengambilan Ubat-Ubatan

Bil	Perkara	Sangat Tidak Setuju	Tidak Setuju	Neutral	Setuju	Sangat Setuju
		5	4	3	2	1
1	Dalam sebulan yang lepas, saya kerap tidak mengambil ubat seperti yang diarahkan oleh doktor.	✓				
2	Dalam sebulan yang lepas, saya mengurangkan pengambilan ubat apabila berasa sihat.	✓				
3	Dalam sebulan yang lepas, saya mengambil ubat secara berselang-seli.	✓				
4	Saya sering lewat/terlepas untuk temujanji pengambilan ubat susulan di kaunter farmasi.	✓				
5	Daripada bekalan ubat yang diterima, saya mempunyai banyak lebihan ubat di rumah.		✓			
6	Saya hanya mengambil sebahagian sahaja daripada ubat yang diberikan kerana merasakan ianya tidak perlu/tidak penting.		✓			
7	Dalam sebulan yang lepas, saya sering terlupa untuk mengambil ubat saya.		✓			
8	Saya sering mengurangkan pengambilan ubat kerana bimbang akan kesan sampingnya terhadap badan.	✓				
9	Saya tidak mengambil ubat apabila tiada sesiapa mengingatkan saya.		✓			
10	Saya tidak begitu pasti tentang dos ubat yang perlu diambil setiap hari.		✓			
11	Saya tidak boleh menguruskan pengambilan ubat saya dengan baik.		✓			
12	Ketiadaan sokongan atau pertolongan dari orang tersayang menyebabkan saya tidak bermotivasi untuk mengambil ubat yang diberikan oleh doktor.		✓			
Jumlah		25	28	0	0	0
(Skor minimum = 12; Skor maksimum = 60)		53				

Figure 3.2.2.6-4 Printed Report Bahagian 1



KEMENTERIAN KESIHATAN MALAYSIA

Hospital Pakar Sultanah Fatimah

**ALAT PENGUKURAN TAHAP KEPATUHAN PESAKIT TERHADAP PENGAMBILAN UBAT DI MALAYSIA
(MyMAAT)**

Bahagian II : Kategori Kepatuhan Pesakit Terhadap Pengambilan Ubat-Ubatan

Kategori kepatuhan mengikut jumlah skor adalah seperti berikut:

Kategori	Jumlah Skor
Kepatuhan Baik	≥ 54
Kepatuhan Sederhana dan Lemah	< 54

Bahagian III : Rumusan Tahap Kepatuhan Pesakit Terhadap Pengambilan Ubat-Ubatan

Jumlah Skor	53
Kategori Kepatuhan	Kepatuhan Baik
Nota Pegawai Farmasi	moderate tolerance

Pharmacist

: [REDACTED]

Date : 18/08/2021

Module : MTAC

Figure 3.2.2.6-4 Printed Report Bahagian 1

3.2.3 Create New MTAC Reporting With Specific Details

3.2.3.1 Chronic Kidney Disease

This function allows user to record Specific Details for Chronic Kidney Disease for MTAC patients.

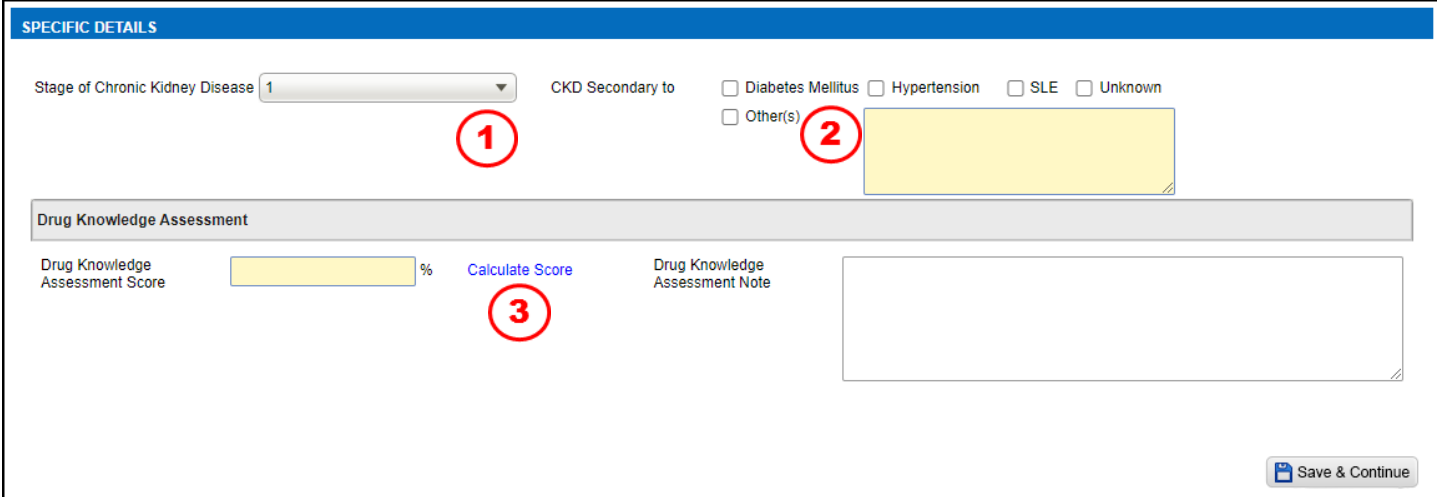


Figure 3.2.3.1-1 Specific Details – Chronic Kidney Disease

Note

Repeat **STEP 1 to 16** as in 3.2.1 Create New MTAC Reporting with No Specific Details before performing MTAC Reporting - Specific Details for Chronic Kidney Disease.

STEP 1

Select **Stage of Chronic Kidney Disease** from the drop down box

- 1
- 2
- 3a
- 3b
- 4
- 5

STEP 2

Select the check box for **CKD Secondary to** as below:

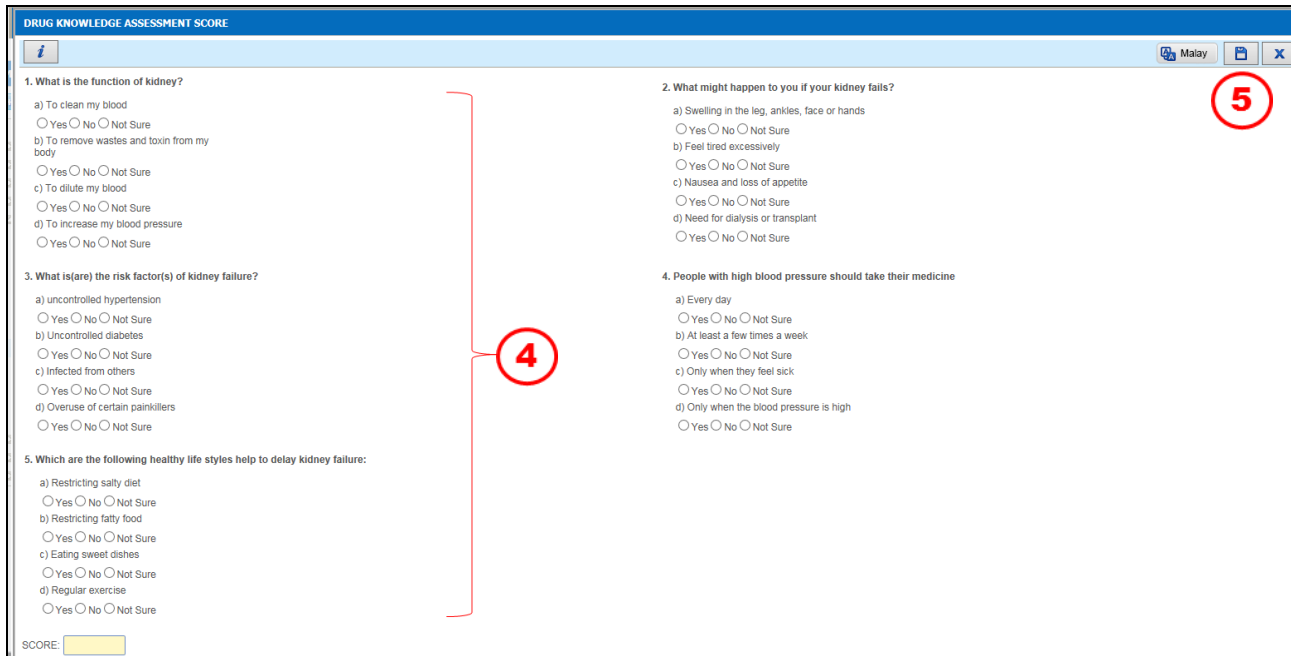
- Diabetes Mellitus
- Hypertension
- SLE
- Unknown
- Other(s)

Note

Blank fields will be enabled if user selects 'Other(s)' radio button.

STEP 3

Click on the [Calculate Score](#) hyperlink and window for 'Drug Knowledge Assessment Score' will be displayed as shown in Figure 3.2.3.1-2



DRUG KNOWLEDGE ASSESSMENT SCORE

1. What is the function of kidney?

a) To clean my blood
 Yes No Not Sure

b) To remove wastes and toxin from my body
 Yes No Not Sure

c) To dilute my blood
 Yes No Not Sure

d) To increase my blood pressure
 Yes No Not Sure

3. What is(are) the risk factor(s) of kidney failure?

a) uncontrolled hypertension
 Yes No Not Sure

b) Uncontrolled diabetes
 Yes No Not Sure

c) Infected from others
 Yes No Not Sure

d) Overuse of certain painkillers
 Yes No Not Sure

5. Which are the following healthy life styles help to delay kidney failure:

a) Restricting salty diet
 Yes No Not Sure

b) Restricting fatty food
 Yes No Not Sure

c) Eating sweet dishes
 Yes No Not Sure

d) Regular exercise
 Yes No Not Sure

2. What might happen to you if your kidney fails?

a) Swelling in the leg, ankles, face or hands
 Yes No Not Sure

b) Feel tired excessively
 Yes No Not Sure

c) Nausea and loss of appetite
 Yes No Not Sure

d) Need for dialysis or transplant
 Yes No Not Sure

4. People with high blood pressure should take their medicine

a) Every day
 Yes No Not Sure

b) At least a few times a week
 Yes No Not Sure

c) Only when they feel sick
 Yes No Not Sure

d) Only when the blood pressure is high
 Yes No Not Sure

SCORE:


Figure 3.2.3.1-2 Drug Knowledge Assessment Score

STEP 4


Answer the questions for **Drug Knowledge Assessment** by checking the radio button for below:

1. What is the function of kidney?
2. What might happen to you if your kidney fails?
3. What is (are) the risk factor(s) of kidney failure?
4. People with high blood pressure should take their medicine
5. Which are the following healthy life styles help to delay kidney failure:

Note

- The questions are not mandatory to be answered.
- Click on the  button to view the questions in Malay language.
- Score will be automatically calculated and automatically displayed.

STEP 5

Click on the  button to save the answered question(s)

STEP 6

Click on the  button to confirm save record

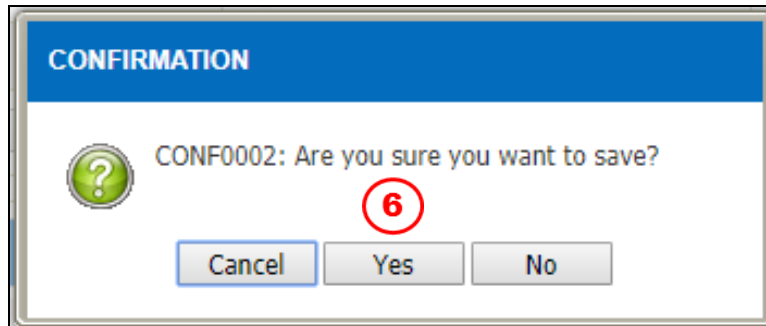



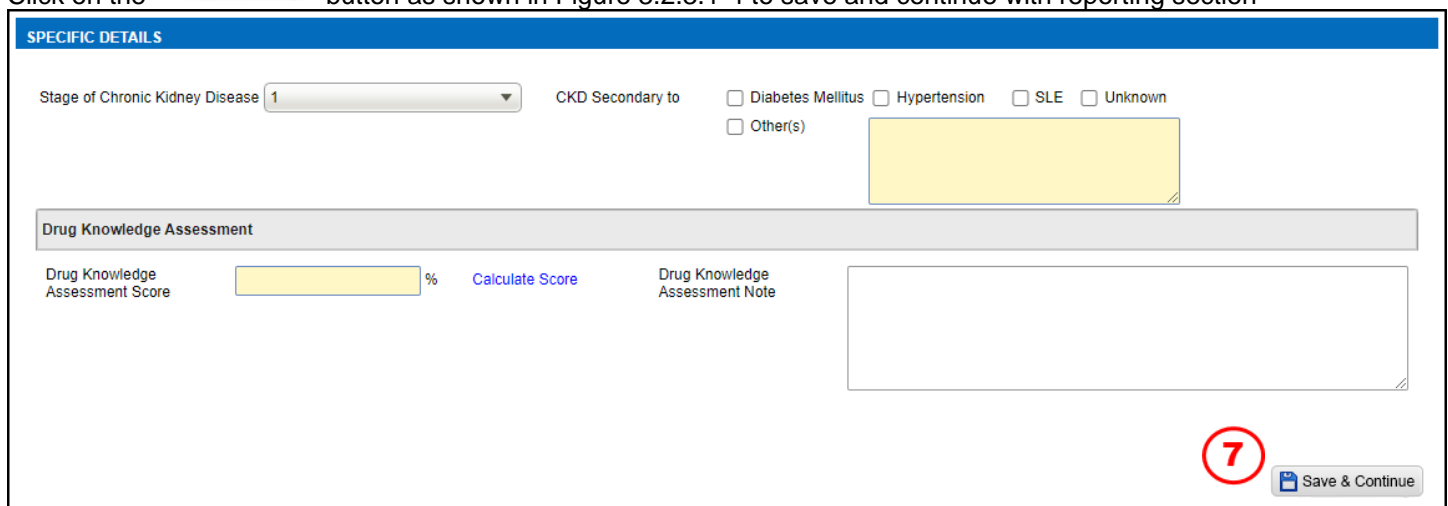
Figure 3.2.3.1-3 Confirmation Alert Message

Note

Insert Drug Knowledge Assessment Note in the free text as per Figure 3.2.3.1-4

STEP 7

Click on the  button as shown in Figure 3.2.3.1-4 to save and continue with reporting section



The form is titled "SPECIFIC DETAILS" and contains the following fields and controls:

- Stage of Chronic Kidney Disease: A dropdown menu with the value "1".
- CKD Secondary to: A group of checkboxes including "Diabetes Mellitus", "Hypertension", "SLE", "Unknown", and "Other(s)".
- Drug Knowledge Assessment: A section with a "Drug Knowledge Assessment Score" field (a yellow input box followed by a "%" sign) and a "Calculate Score" button.
- Drug Knowledge Assessment Note: A large text area for notes.
- At the bottom right, there is a "Save & Continue" button with a red circle containing the number "7" overlaid on it.

Figure 3.2.3.1-4 Specific Details – Chronic Kidney Disease

STEP 8

Click on the  button to confirm save record

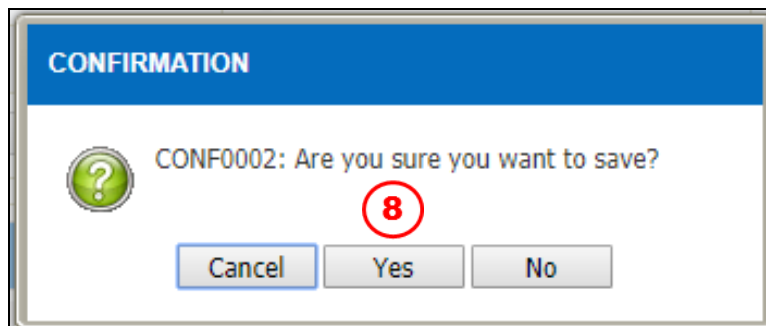



Figure 3.2.3.1-5 Confirmation Alert Message

STEP 9

Click on the  button to confirm record

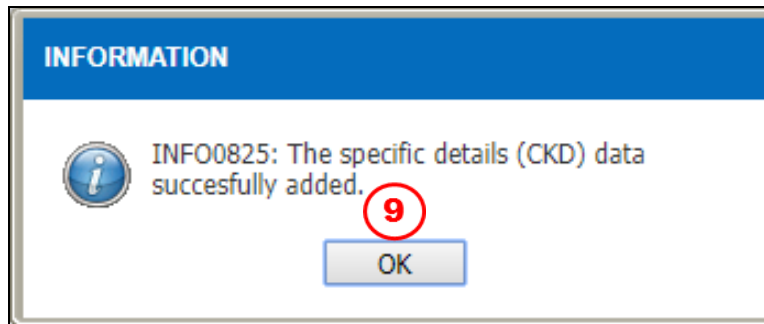


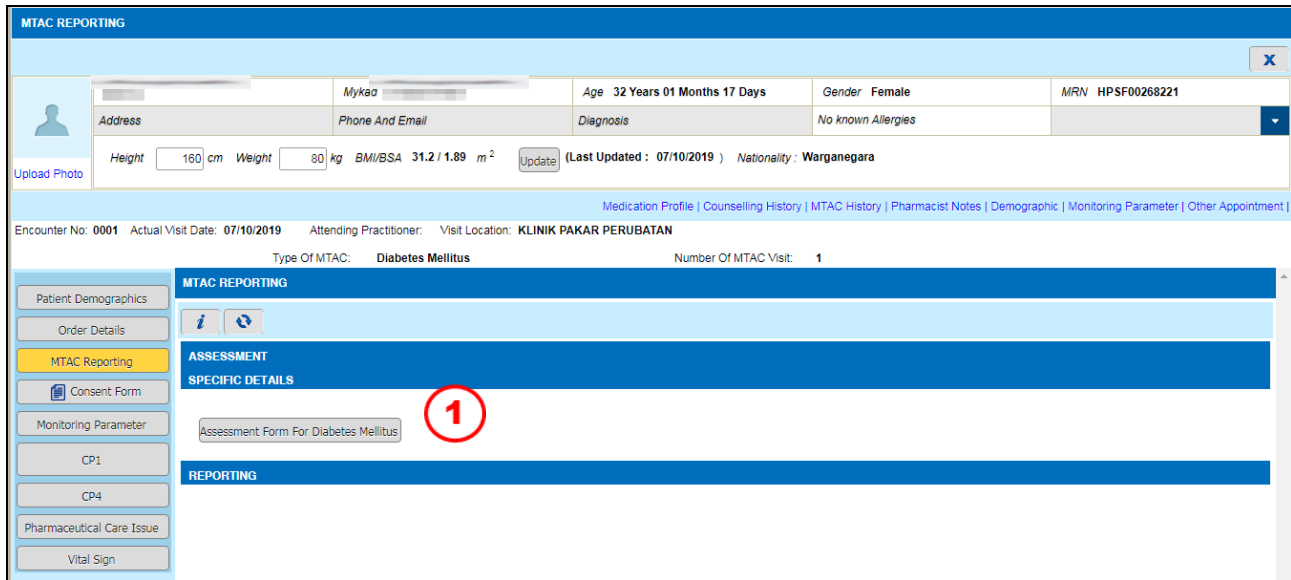
Figure 3.2.3.1-6 Information alert message

Note

For '**Reporting**' section, repeat steps from the **Note (page 28) to Step 32** as in 3.2.1 Create New MTAC Reporting with No Specific Details.

3.2.3.2 Diabetes Mellitus

This function allow user to record Specific Details for Diabetes Mellitus for MTAC patient



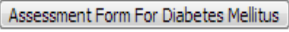
The screenshot displays the 'MTAC REPORTING' interface. At the top, there is a patient information summary including name (Mykaa), age (32 Years 01 Months 17 Days), gender (Female), and MRN (HPSF00268221). Below this, there are fields for address, phone and email, diagnosis, and allergies. A section for physical attributes includes height (160 cm), weight (80 kg), and BMI/BSA (31.2 / 1.89 m²), with an 'Update' button and a note '(Last Updated : 07/10/2019)'. The interface also shows the encounter number (0001), actual visit date (07/10/2019), attending practitioner, and visit location (KLINIK PAKAR PERUBATAN). The 'Type Of MTAC' is 'Diabetes Mellitus' and the 'Number Of MTAC Visit' is '1'. On the left, there is a navigation menu with buttons for 'Patient Demographics', 'Order Details', 'MTAC Reporting', 'Consent Form', 'Monitoring Parameter', 'CP1', 'CP4', 'Pharmaceutical Care Issue', and 'Vital Sign'. The main content area is divided into sections: 'MTAC REPORTING', 'ASSESSMENT', 'SPECIFIC DETAILS', and 'REPORTING'. In the 'SPECIFIC DETAILS' section, there is a button labeled 'Assessment Form For Diabetes Mellitus' which is circled in red with the number '1'.

Figure 3.2.3.2-1 Specific Details - Diabetes Mellitus

Note

Repeat **STEP 1 to 16** as in 3.2.1 Create New MTAC Reporting with No Specific Details before performing MTAC Reporting - Specific Details Assessment Form for Diabetes Mellitus.


STEP 1

Click on the  button to view the specific details





STEP 2

Select the check box to answer the question(s)

Note

- The questions are not mandatory to be answered
- Click on the  button to print the assessment form
- 'Diabetes Mellitus Assessment' as shown in Figure 3.2.3.2-2 will be used during MTAC counselling

DIABETES MELLITUS ASSESSMENT

1. Kencing manis (Diabetes Mellitus) adalah penyakit? 2

- Paras gula dalam darah tinggi
- Kolesterol dalam darah tinggi
- Tekanan Darah Tinggi
- Tidak pasti

2. Fungsi gula (glukosa) di dalam badan adalah untuk?

- Menghasilkan tenaga
- Menghasilkan Oksigen
- Membina tisu badan
- Tidak pasti

3. Penyakit kencing manis disebabkan oleh factor berikut?

- Berat badan berlebihan
- Insulin dalam badan tidak mencukupi atau resistant
- Sejarah keluarga
- Virus atau jangkitan kuman
- Tidak pasti

4. Yang manakah antara berikut tanda-tanda paras gula di dalam darah tinggi (Hiperglisemia)?

- Mulut kering dan dahaga
- Turun berat badan
- Kerap kencing
- Kabur penglihatan
- Lapar

5. Yang manakah antara berikut tanda-tanda paras gula di dalam darah rendah (Hipoglisemia)?

- Tangan menggigil
- Berpeluh sejuk
- Kerap kencing
- Lapar
- Letham dan tidak bertenaga

6. Paras gula didalam darah rendah juga boleh berlaku sekiranya anda?

- Bersenam keterlaluan
- Tidak makan selepas mengambil ubat
- Mengambil ubat atau insulin berlebihan
- Makan berlebihan

7. Jika anda mengalami tanda-tanda hipoglisemia, apa yang patut dilakukan?

- Minum jus atau ambil gula-gula
- Periksa paras gula menggunakan glucometer
- Baring dan rehat
- Suntik insulin
- Bersenam

8. Apakah komplikasi (kesan buruk) penyakit kencing manis?

- Penglihatan kabur / katarak
- Penyakit buah pinggang
- Penyakit jantung
- Penyakit saraf? kebas-kebas
- Strok
- Mudah dapat jangkitan kuman
- Ulser

9. Apakah nama ubat kencing manis yang anda ambil? 3

- Metformin (Glucophage)
- Gliclazide (Diamicon)
- Gliclazide MR (Diamicon MR)
- Glibenclamide
- Rosiglitazone (Avandia)
- Acarbose
- Repaglinide (Novonorm)
- Insulin _____
- Tidak pasti

10. Bagaimana cara anda mengambil ubat-ubatan berkenaan?

- 30 minit sebelum makan
- Bersama makanan
- Sebaik selepas makan
- Sebaik sebelum makan
- Pada bila-bila masa

11. Adakah anda ada mengalami tanda-tanda berikut selepas mengambil ubat-ubatan kencing manis?

- Berat badan meningkat
- Kembang perut
- Loya / muntah
- Clirit-birit / sembelit
- Perut berasa pedih / tidak selesa

12. Sekiranya anda terlupa mengambil /makan ubat-ubatan kencing manis, apakah yang anda lakukan?

- Makan ubat sebaik teringat
- Lupakan saja dos yang tertinggal
- Gandakan dos ubat seterusnya
- Memeriksa paras gula dalam darah

13. Apakah sasaran? paras gula dalam darah yang perlu dicapai oleh setiap pesakit diabetes?

- HbA1c <7 %
- Plasma glukosa (puasa) 4.4 ? 6.1 mmol/L
- 2 jam selepas makan /rambang 4.4 ?8.0mmol/l
- Plasma Glukosa > 10.00mmol/l (puasa)

Sila jawab soalan berikut, sekiranya anda mengambil suntikan insulin?

14. Dimanakah anda menyimpan Stok insulin?

- Dalam peti sejuk beku (0u00EFu00BFu00BDC)
- Dalam peti sejuk (2 ?8 u00BAC)
- Atas peti sejuk
- Dalam almari

15. Dimanakah anda menyimpan Novopen /Humapen yang mengandungi insulin atau insulin yang sedang digunakan?


- Di dalam almari berkunci
- Di dalam peti sejuk
- Di dalam beg tangan
- Pada suhu bilik

16. Berapa kerap anda menukar jarum untuk suntikan insulin?

- Setiap kali digunakan
- Selepas 3 ?4 kali digunakan
- Sehingga jarum tumpul
- Sekali seminggu

Figure 3.2.3.2-2 Diabetes Mellitus Assessment

STEP 3

Click on the  button to save the answered question(s)

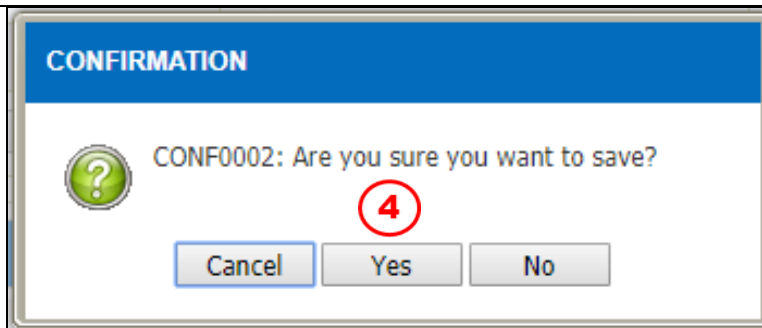


Figure 3.2.3.2-3 Confirmation Alert Message

STEP 4

Click on the  button to confirm save record

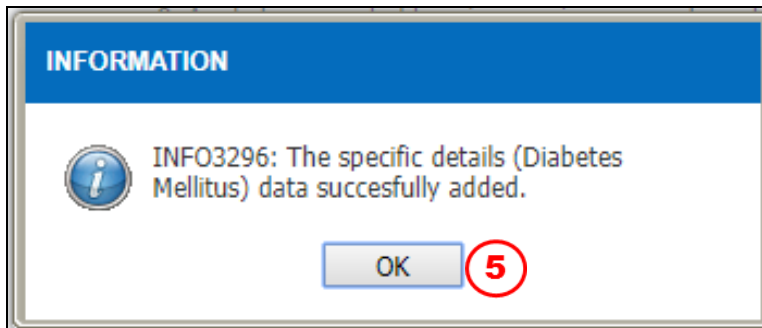



Figure 3.2.3.2-4 Information Alert Message

STEP 5

Click on the  button to confirm record

Note

For 'Reporting' section, repeat **Note (Page 28) to Step 32** as in 3.2.1 Create New MTAC Reporting with No Specific Details.

3.2.3.3 Dialysis

This function allows users to record Specific Details for Dialysis for MTAC patients

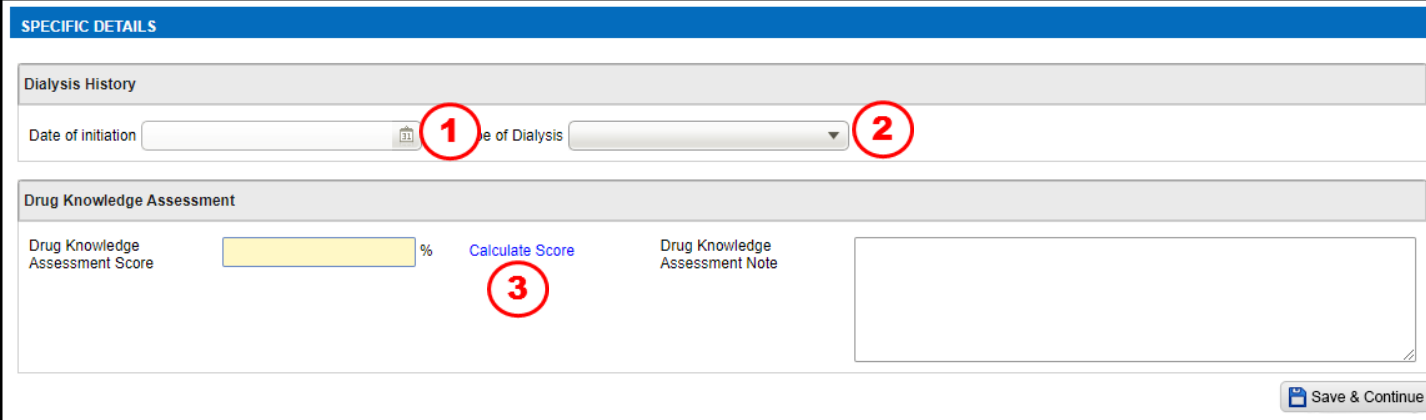



Figure 3.2.3.3-1 Specific Details - Dialysis

Note

Repeat **STEP 1 to 16** as in 3.2.1 Create New MTAC Reporting with No Specific Details before performing MTAC Reporting - Specific Details for Dialysis.

Dialysis History

STEP 1

Click on the  button to select **Date of initiation**

STEP 2

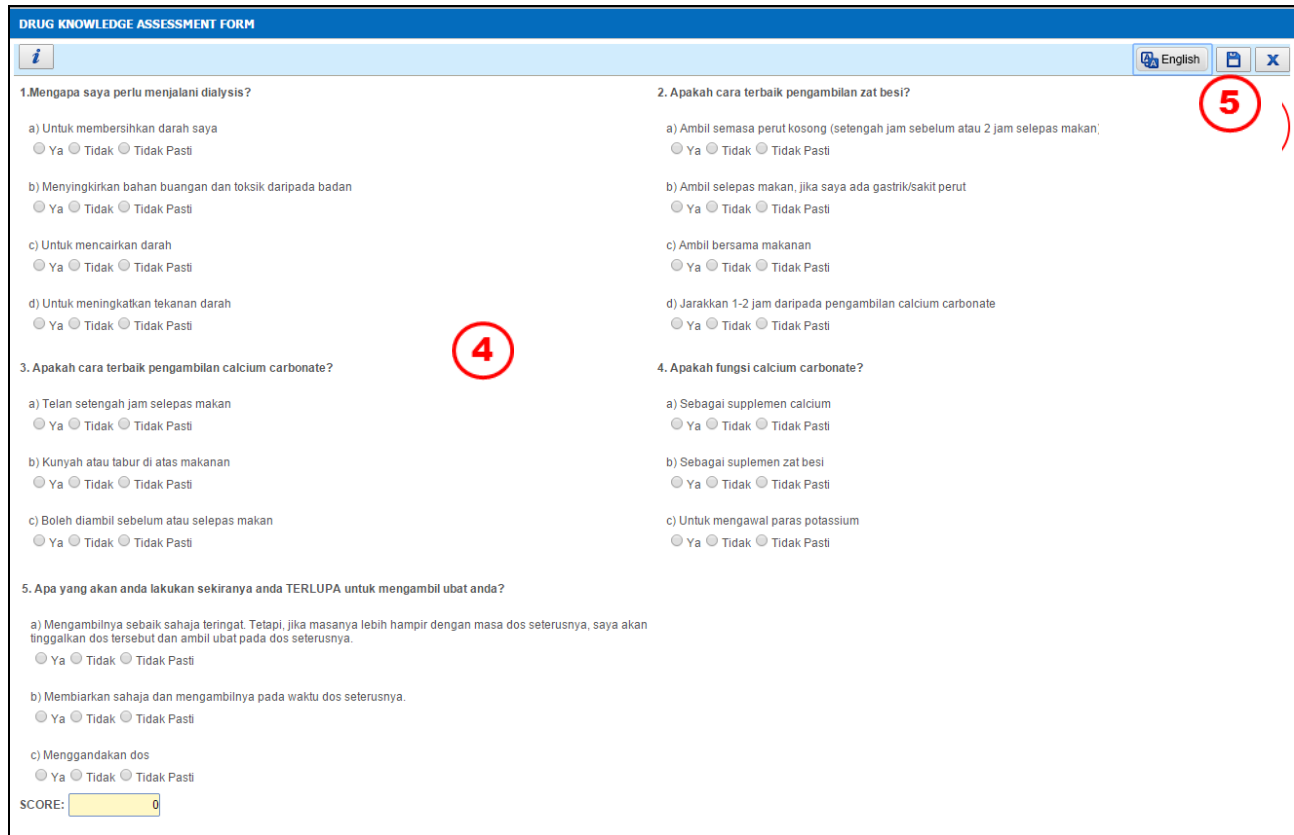
Select **Type of Dialysis** from the dropdown box

- APD
- CAPD
- HD

Drug Knowledge Assessment

STEP 3

Click on the [Calculate Score](#) and hyperlink '**Drug Knowledge Assessment Score** and '**Drug Knowledge Assessment Form**' window will be displayed as shown in Figure 3.2.3.3-2



DRUG KNOWLEDGE ASSESSMENT FORM

English

1. Mengapa saya perlu menjalani dialysis?

a) Untuk membersihkan darah saya
 Ya Tidak Tidak Pasti

b) Menyingkirkan bahan buangan dan toksik daripada badan
 Ya Tidak Tidak Pasti

c) Untuk mencairkan darah
 Ya Tidak Tidak Pasti

d) Untuk meningkatkan tekanan darah
 Ya Tidak Tidak Pasti

2. Apakah cara terbaik pengambilan zat besi?

a) Ambil semasa perut kosong (setengah jam sebelum atau 2 jam selepas makan).
 Ya Tidak Tidak Pasti

b) Ambil selepas makan, jika saya ada gastrik/sakit perut
 Ya Tidak Tidak Pasti

c) Ambil bersama makanan
 Ya Tidak Tidak Pasti

d) Jarakkan 1-2 jam daripada pengambilan calcium carbonate
 Ya Tidak Tidak Pasti

3. Apakah cara terbaik pengambilan calcium carbonate?

a) Telan setengah jam selepas makan
 Ya Tidak Tidak Pasti

b) Kunyah atau tabur di atas makanan
 Ya Tidak Tidak Pasti

c) Boleh diambil sebelum atau selepas makan
 Ya Tidak Tidak Pasti

4. Apakah fungsi calcium carbonate?

a) Sebagai suplemen calcium
 Ya Tidak Tidak Pasti

b) Sebagai suplemen zat besi
 Ya Tidak Tidak Pasti

c) Untuk mengawal paras potassium
 Ya Tidak Tidak Pasti

5. Apa yang akan anda lakukan sekiranya anda TERLUPA untuk mengambil ubat anda?

a) Mengambilnya sebaik sahaja teringat. Tetapi, jika masanya lebih hampir dengan masa dos seterusnya, saya akan tinggalkan dos tersebut dan ambil ubat pada dos seterusnya.
 Ya Tidak Tidak Pasti

b) Membiarkannya sahaja dan mengambilnya pada waktu dos seterusnya.
 Ya Tidak Tidak Pasti

c) Menggandakan dos
 Ya Tidak Tidak Pasti

SCORE:


Figure 3.2.3.3-2 Specific Details - Dialysis

STEP 4


Answer the questions for **Drug Knowledge Assessment Form** by checking the radio button for below:

1. **Why do I have to do dialysis?**
2. **What is (are) the appropriate way(s) to take iron tablet?**
3. **What is (are) the appropriate way(s) to take calcium carbonate?**
4. **What is (are) function(s) of calcium carbonate?**
5. **What do you usually do when you missed a dose(s)?**

Note

- The questions are not mandatory to be answered.
- Click on the  button to view the questions in Malay language
- Score will be automatically calculated and automatically displayed

STEP 5

Click on the  button to save the answered questions(s)

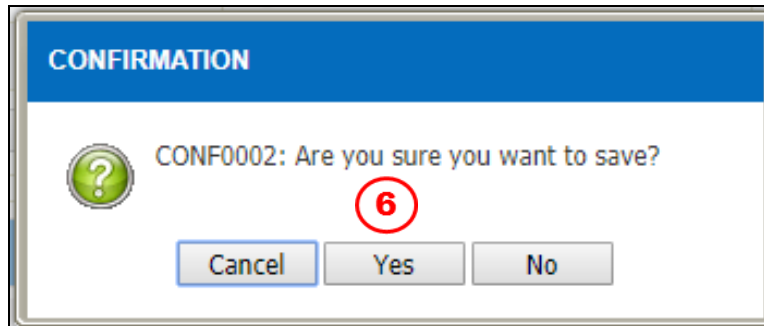


Figure 3.2.3.3-3 Confirmation Alert Message


STEP 6

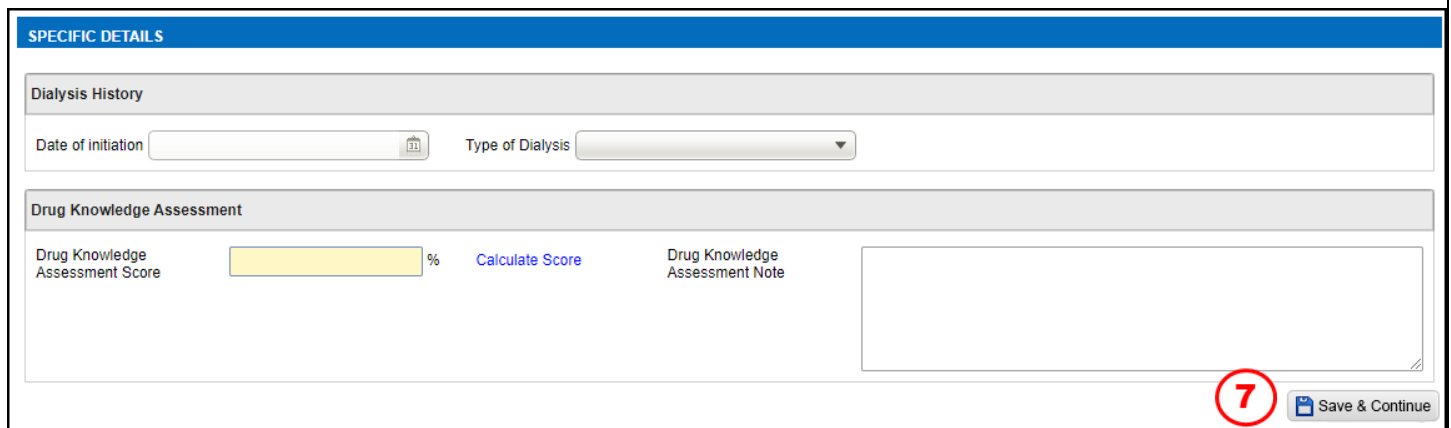
Click on the  button to confirm save record

Note

Insert Drug Knowledge Assessment Note in the free text as per Figure 3.2.3.3-4

STEP 7

Click on the  button as shown in Figure 3.2.3.3-4 to save and continue with reporting section



The "SPECIFIC DETAILS" form is divided into two main sections. The top section, "Dialysis History", contains a "Date of initiation" text box with a calendar icon and a "Type of Dialysis" dropdown menu. The bottom section, "Drug Knowledge Assessment", features a "Drug Knowledge Assessment Score" label next to a yellow progress bar and a percentage sign, followed by a "Calculate Score" button. To the right is a "Drug Knowledge Assessment Note" text area. At the bottom right of the form is a "Save & Continue" button with a floppy disk icon, which is circled in red with the number "7".

Figure 3.2.3.3-4 Specific Details

STEP 8

Click on the  button to confirm save record

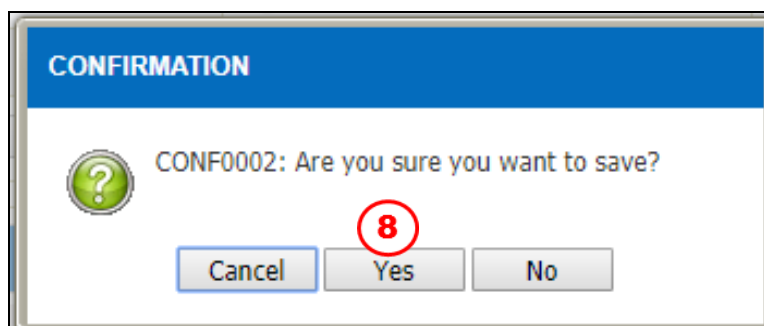



Figure 3.2.3.3-5 Confirmation Alert Message

STEP 9

Click on the  button to confirm record

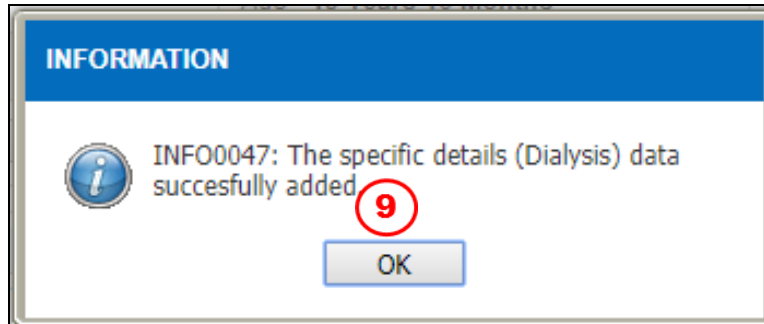


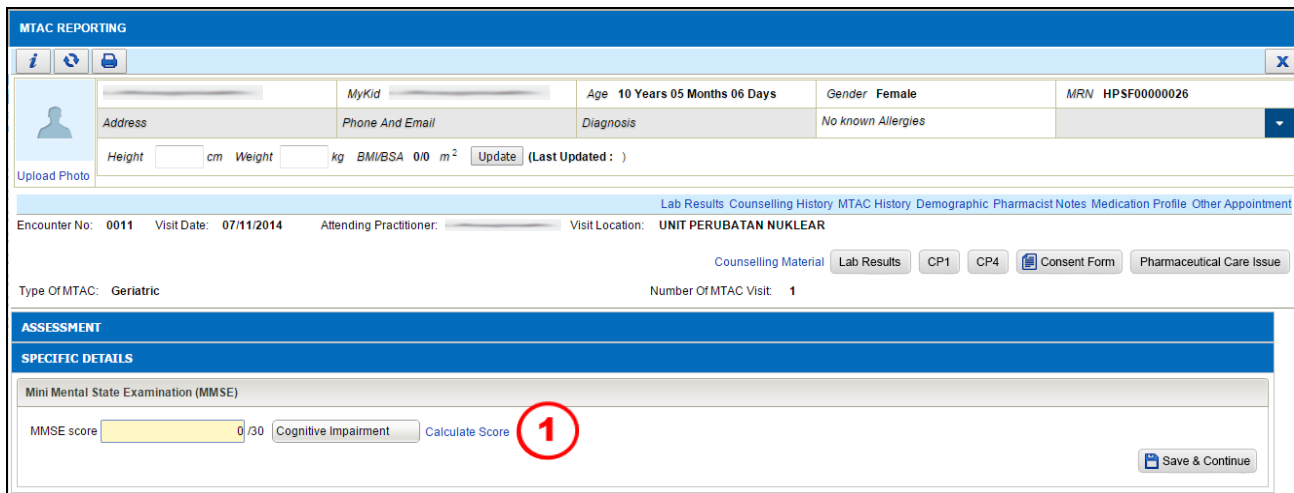
Figure 3.2.3.3-6 Information alert message

Note

For 'Reporting' section, repeat **Note (Page 28) to Step 32** as in 3.2.1 Create New MTAC Reporting with No Specific Details.

3.2.3.4 Geriatric

This function allows users to record Specific Details for Geriatric for MTAC patients



The screenshot displays the 'MTAC REPORTING' interface. At the top, there are navigation icons and a close button. Below this, patient information is shown in a grid: MyKid, Age (10 Years 05 Months 06 Days), Gender (Female), and MRN (HPSF0000026). There are also fields for Address, Phone And Email, Diagnosis, and No known Allergies. A section for physical attributes includes Height (cm), Weight (kg), and BMI/BSA (0/0 m²), with an 'Update' button and '(Last Updated :)' text. An 'Upload Photo' button is also present. Below this, there are links for 'Lab Results', 'Counselling History', 'MTAC History', 'Demographic', 'Pharmacist Notes', 'Medication Profile', and 'Other Appointment'. Patient encounter details include Encounter No: 0011, Visit Date: 07/11/2014, Attending Practitioner, and Visit Location: UNIT PERUBATAN NUKLEAR. There are buttons for 'Counselling Material', 'Lab Results', 'CP1', 'CP4', 'Consent Form', and 'Pharmaceutical Care Issue'. The 'Type Of MTAC' is set to 'Geriatric' and the 'Number Of MTAC Visit' is 1. The 'ASSESSMENT' section is expanded to show 'SPECIFIC DETAILS'. Under 'Mini Mental State Examination (MMSE)', there is an input field for 'MMSE score' with the value '0/30', a 'Cognitive impairment' radio button, and a 'Calculate Score' button. A red circle with the number '1' is drawn around the 'Calculate Score' button. A 'Save & Continue' button is located at the bottom right of the MMSE section.

Figure 3.2.3.4-1 Specific Details - Geriatric

Note

Repeat **STEP 1 to 16** as in 3.2.1 Create New MTAC Reporting with No Specific Details before performing MTAC Reporting - Specific Details for Geriatric.

STEP 1

Click on the [Calculate Score](#) hyperlink for **MMSE Score** and 'Mini Mental State Examination (MMSE) – Orientasi Masa' window will be displayed as shown in Figure 3.2.3.4-2

STEP 2

Answer questions in **Mini Mental State Examination (MMSE)** by selecting radio button as shown in Figure 3.2.3.4-2

Note

- The questions are not mandatory to be answered.
- Score will be automatically calculated and automatically displayed.

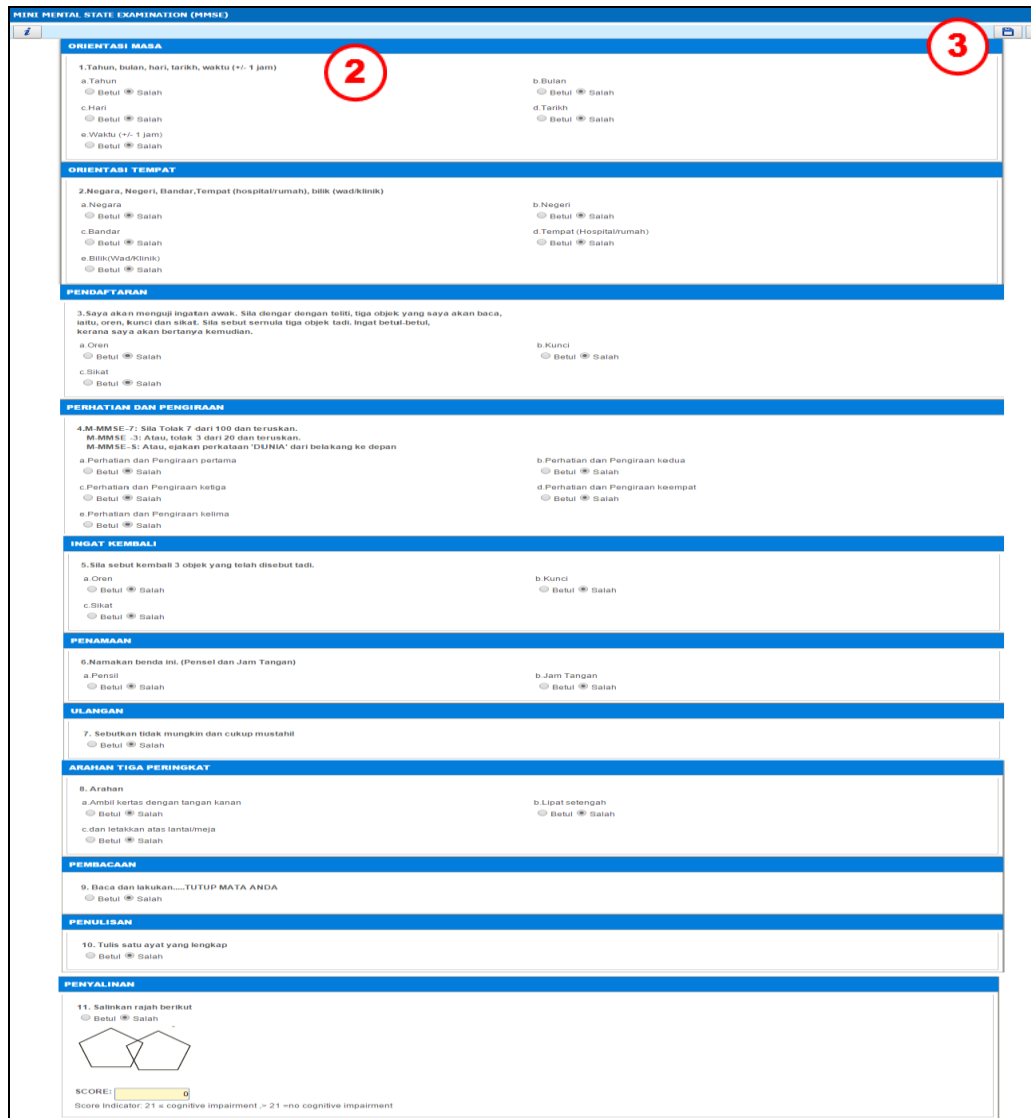



Figure 3.2.3.4-2 Mini Mental State Examination (MMSE)

STEP 3

Click on the  button to save the answered questions(s)

STEP 4

Click on the  button to confirm save record

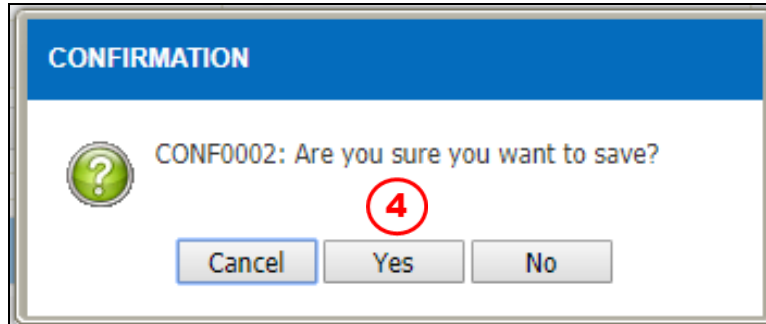

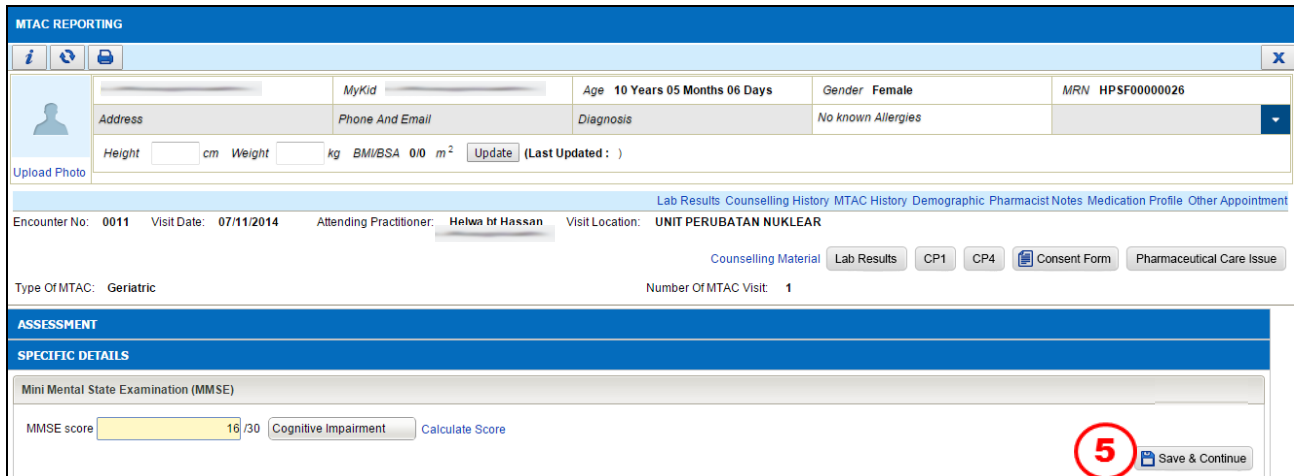


Figure 3.2.3.4-3 Confirmation Alert Message

STEP 5

Click on the  button as shown in Figure 3.2.3.4-1 to save and continue with reporting section



A screenshot of the "MTAC REPORTING" form. The form includes fields for patient information (MyKid, Age, Gender, MRN), address, phone, email, diagnosis, and allergies. It also shows encounter details (Encounter No: 0011, Visit Date: 07/11/2014, Attending Practitioner: Helwa bt Hassan, Visit Location: UNIT PERUBATAN NUKLEAR) and assessment details (Type Of MTAC: Geriatric, Number Of MTAC Visit: 1). The "ASSESSMENT" section is expanded to show "SPECIFIC DETAILS" for a Mini Mental State Examination (MMSE), with a score of 16/30 and a "Cognitive Impairment" button. A "Save & Continue" button is highlighted with a red circle and the number "5".

Figure 3.2.3.4-4 Specific Details - Geriatric

STEP 6

Click on the  button to confirm save record

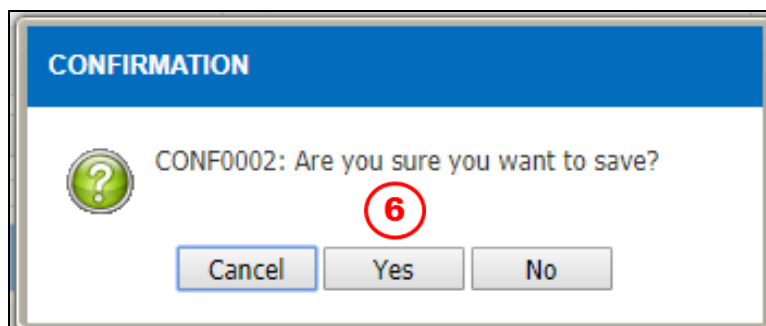


Figure 3.2.3.4-5 Confirmation Alert Message

STEP 7

Click on the  button to confirm record

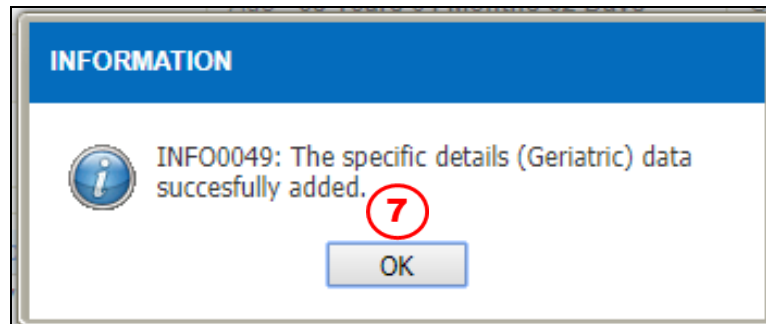


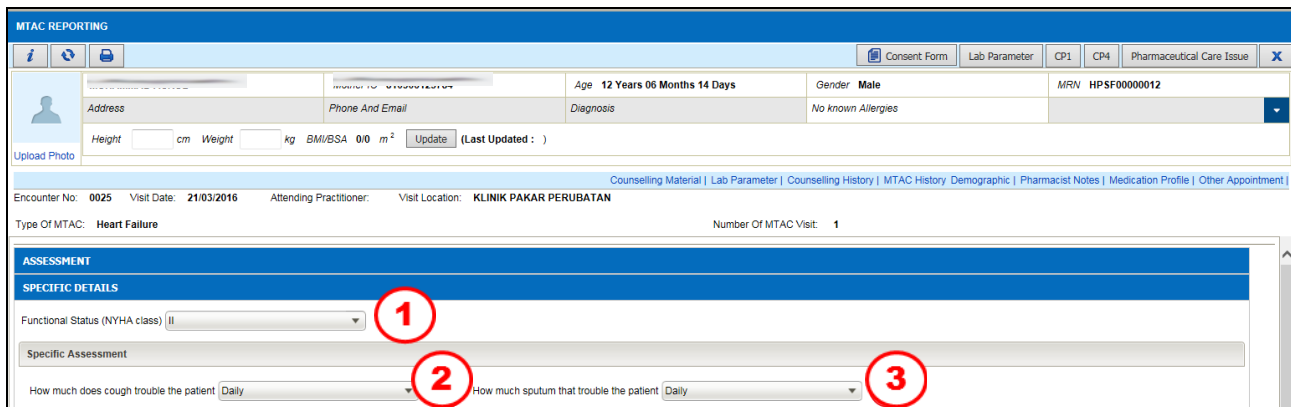
Figure 3.2.3.4-6 Information alert message

Note

For 'Reporting' section, repeat **Note (Page 28) to Step 32** as in 3.2.1 Create New MTAC Reporting with No Specific Details.

3.2.3.5 Heart Failure

This function allow user to record Specific Details for Heart Failure for MTAC patient.



The screenshot shows the 'MTAC REPORTING' interface. At the top, there are navigation tabs for 'Consent Form', 'Lab Parameter', 'CP1', 'CP4', and 'Pharmaceutical Care Issue'. Below this is a patient information section with fields for 'Address', 'Phone And Email', 'Age' (12 Years 06 Months 14 Days), 'Gender' (Male), and 'MRN' (HPSF0000012). There are also fields for 'Height' (cm), 'Weight' (kg), and 'BMI/BSA' (0/0 m²). A 'Type Of MTAC' dropdown is set to 'Heart Failure'. The main section is titled 'ASSESSMENT' and 'SPECIFIC DETAILS'. It contains three dropdown menus: 'Functional Status (NYHA class)' (1), 'How much does cough trouble the patient' (2), and 'How much sputum that trouble the patient' (3).

Figure 3.2.3.5 Specific Details - Heart Failure

Note

Repeat **STEP 1 to 16** as in 3.2.1 Create New MTAC Reporting with No Specific Details before performing MTAC Reporting - Specific Details for Heart Failure

STEP 1

Select **Functional Status (NYHA class)** from the drop down box

- I
- II
- III
- IV

Specific Assessment

STEP 2

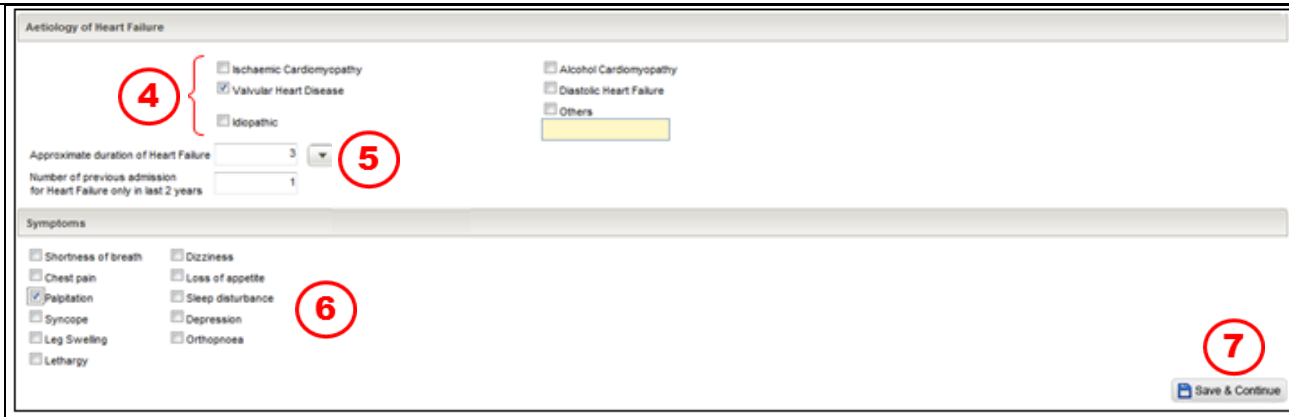
Select **How much does cough trouble the patient** from the drop down box

- Not Present
- Few Days/Month
- Few Days/Week
- Daily

STEP 3

Select **How much sputum that trouble the patient** from the drop down box

- Not Present
- Few Days/Month
- Few Days/Week
- Daily



The screenshot shows a web form titled "Aetiology of Heart Failure". It contains several sections: "Aetiology of Heart Failure" with checkboxes for Ischaemic Cardiomyopathy, Valvular Heart Disease (checked), Idiopathic, Alcohol Cardiomyopathy, Diastolic Heart Failure, and Others; "Approximate duration of Heart Failure" with a dropdown menu set to 3; "Number of previous admission for Heart Failure only in last 2 years" with a text input set to 1; "Symptoms" with checkboxes for Shortness of breath, Chest pain, Palpitation (checked), Syncope, Leg Swelling, Lethargy, Dizziness, Loss of appetite, Sleep disturbance, Depression, and Orthopnoea; and a "Save & Continue" button. Red circles with numbers 4 through 7 highlight specific elements: 4 points to the Aetiology checkboxes, 5 to the duration dropdown, 6 to the Symptoms checkboxes, and 7 to the Save & Continue button.

Figure 3.2.3.5-2 Specific details - Heart Failure

STEP 4

Select the check box for **Aetiology of Heart Failure** as below:

- Ischaemic Cardiomyopathy
- Valvular Heart Disease
- Idiopathic
- Alcohol Cardiomyopathy
- Diastolic Hear Failure
- Others

Note

Blank fields will be enabled only if user selects 'Others' from the check box

STEP 5

Enter **Approximate duration of Heart Failure** and select from the drop down box

- Months
- Years


STEP 6

Select the check box for **Symptoms** as below:

- Shortness of breath
- Chest pain
- Palpitation
- Syncope
- Leg Swelling
- Lethargy
- Dizziness
- Loss of appetite
- Sleep disturbance

- Depression
- Orthopnea

STEP 7

Click on the  button as shown in Figure 3.2.3.5-1 to save and continue with reporting section

STEP 8

Click on the  button to confirm save record

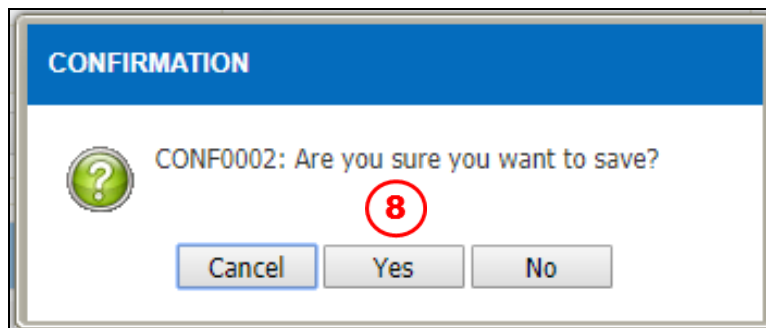



Figure 3.2.3.5-3 Confirmation Alert Message

STEP 9

Click on the  button to confirm record

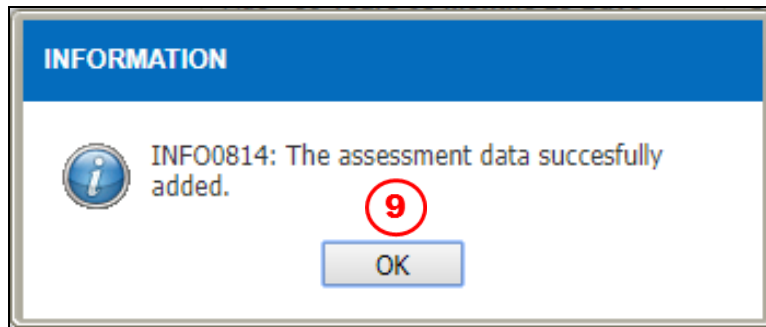


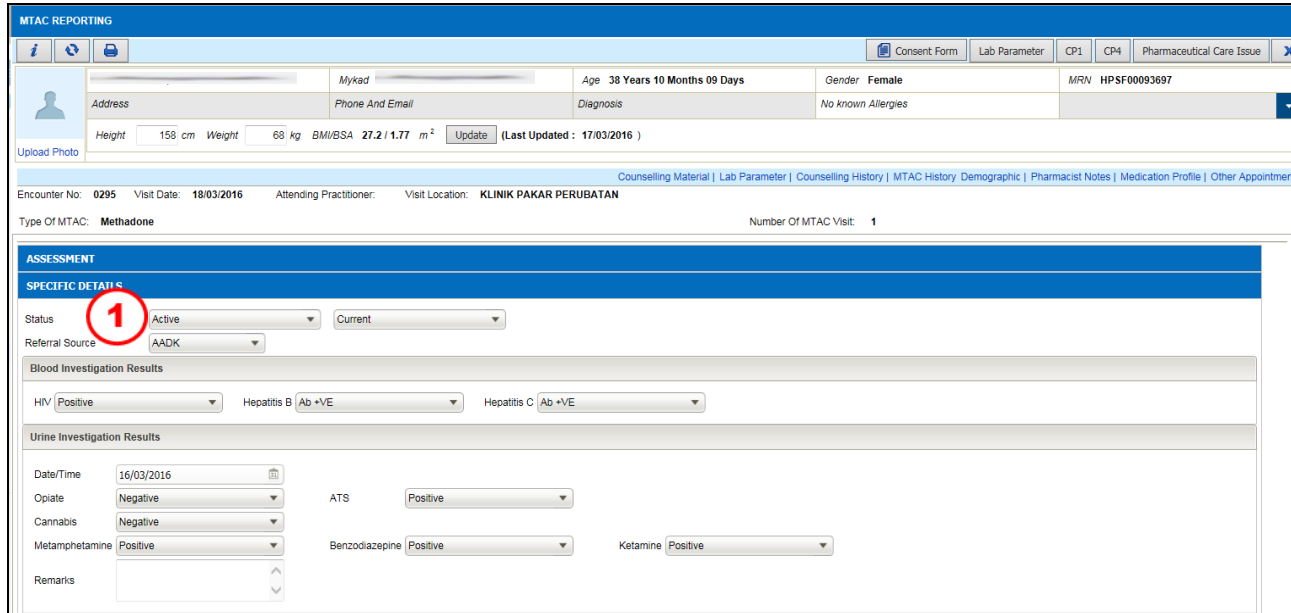
Figure 3.2.3.5-4 Information Alert Message

Note

For 'Reporting' section, repeat **Note (Page 28) to Step 32** as in 3.2.1 Create New MTAC Reporting with No Specific Details

3.2.3.6 Methadone

This function allow user to record Specific Details for Methadone for MTAC patient



The screenshot displays the 'MTAC REPORTING' interface. At the top, there are navigation tabs for 'Consent Form', 'Lab Parameter', 'CP1', 'CP4', and 'Pharmaceutical Care Issue'. Below this, patient information is shown in a grid format, including 'Mykad', 'Age 38 Years 10 Months 09 Days', 'Gender Female', and 'MRN HPSF00093697'. A 'Status' dropdown menu is highlighted with a red circle containing the number '1', and it is currently set to 'Active'. Other dropdowns include 'Referral Source' (AADK), 'Blood Investigation Results' (HIV Positive, Hepatitis B Ab +VE, Hepatitis C Ab +VE), and 'Urine Investigation Results' (Opiate Negative, ATS Positive, Cannabis Negative, Metamphetamine Positive, Benzodiazepine Positive, Ketamine Positive). The 'Remarks' field is empty.

Figure 3.2.3.6-1 Specific Details - Methadone

Note

Repeat **STEP 1 to 16** as in 3.2.1 Create New MTAC Reporting with No Specific Details before performing MTAC Reporting - Specific Details for Methadone.

STEP 1

Select **Status** from the drop down box

- Active
- Inactive
- Current
- Re-entry
- Transfer

Select **Referral Source** from the drop down box

- AADK
- NGO
- NSEP
- Others
- Walk In

Note

Blank field will be enabled if user select **Other** from the **Referral Source** drop down box.

Blood Investigation Results

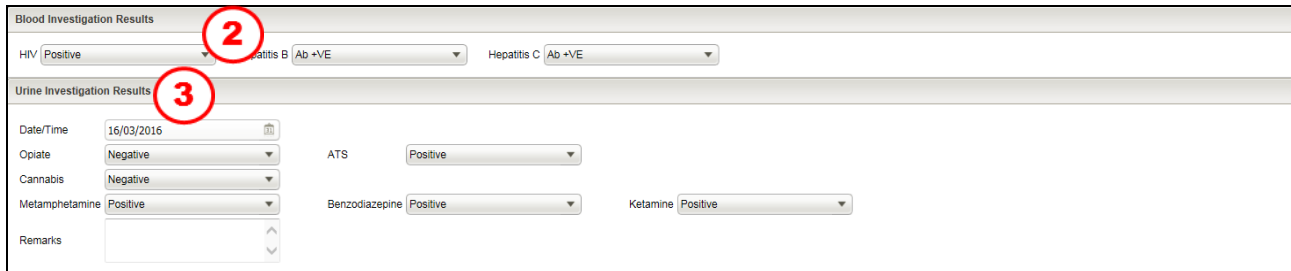


Figure 3.2.3.6-2 Specific Details – Methadone

STEP 2

Select **HIV** from the drop down box

- Negative
- Positive
- Unknown

Select **Hepatitis B** from the drop down box:


- Ab +VE
- Ab –VE
- Ag +VE
- Non-Reactive
- Unknown

Select **Hepatitis C** from the drop down box:

- Ab +VE
- Ab –VE
- Non-Reactive
- Unknown

Urine Investigation Results

STEP 3

Click on the  button to select *sample Date/Time*.

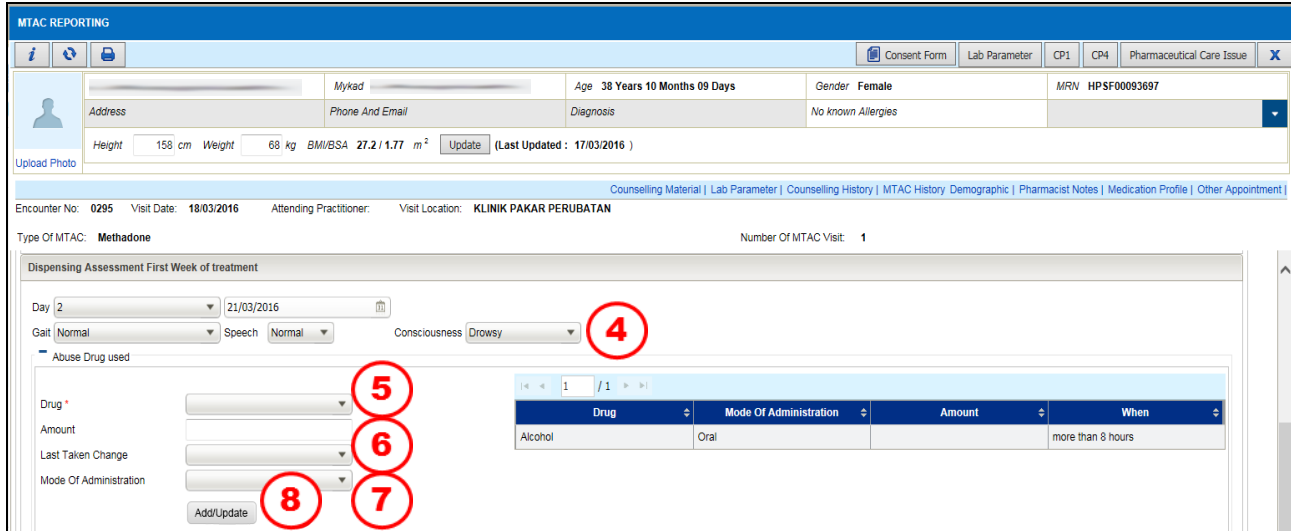
Select **Opiate**, **ATS**, **Cannabis**, **Methamphetamine**, **Benzodiazepine**, and **Ketamine** from the drop down box

- Negative
- Positive

Note

Enter **Remarks** if necessary


Dispensing Assessment First Week of Treatment



The screenshot shows the 'MTAC REPORTING' interface. At the top, there are tabs for 'Consent Form', 'Lab Parameter', 'CP1', 'CP4', and 'Pharmaceutical Care Issue'. Below this, patient information is displayed, including Mykad, Age (38 Years 10 Months 09 Days), Gender (Female), and MRN (HPSF00093697). The 'Dispensing Assessment First Week of treatment' section is active, showing a table with columns for Drug, Mode of Administration, Amount, and When. The table contains one entry: Alcohol, Oral, and more than 8 hours. Red circles are placed over the following elements: 4 (Consciousness dropdown), 5 (Drug dropdown), 6 (Amount dropdown), 7 (Mode of Administration dropdown), and 8 (Add/Update button).

Figure 3.2.3.6-3 Specific Details – Methadone

STEP 4

Select **Day** from the drop down box and click on the  button to select date

Select **Gait** from the drop down box

- Impaired
- Normal

Select **Speech** from the drop down box

- Normal
- Pressured
- Slurred

Select **Consciousness** from the drop down box

- Agitated
- Alert
- Drowsy

Abuse Drug used

STEP 5

Select **Drug** from the drop down box

- ATS
- Alcohol
- Benzodiazepine
- Cannabis
- Mitragynine (Air Ketum)
- Opiate
- Others

Note

Enter **Amount** of drug

STEP 6

Select **Last Taken Change** from the drop down box


- Past 1 hour
- Past 2 hours
- Past 3 hours
- Past 4 hours
- Past 5 hours
- Past 6 hours
- Past 7 hours
- Past 8 hours
- More than 8 hours

STEP 7

Select **Mode of Administration** from the drop down button

- Oral
- Others (please specify)
- Inhale/Snort/Smoke
- Injection

STEP 8

Click on the  button to add drug information on the list.

Evidence of withdrawal 9 <input checked="" type="checkbox"/> Runny nose <input type="checkbox"/> Dilated pupils <input checked="" type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhoea <input type="checkbox"/> Cramps <input type="checkbox"/> Others (can be list more than one)	Evidence of intoxication 10 <input type="checkbox"/> Pin point pupils <input checked="" type="checkbox"/> Heavy eyelids <input type="checkbox"/> Glassy or red eyes <input type="checkbox"/> Smell alcohol <input type="checkbox"/> Unsteady movements <input type="checkbox"/> Others (can be list more than one)	Pharmacist remarks on current dose 11 Too High <input type="text"/>
--	--	--

Figure 3.2.3.6-4 Specific Details – Methadone

STEP 9

Select **Evidence of withdrawal** from the drop down box

- Runny nose
- Dilated pupils
- Nausea and/or vomiting
- Diarrhoea
- Cramps
- Others

STEP 10

Select **Evidence of intoxication** from the drop down box

- Pin point pupils
- Heavy eyelids
- Glassy or red eyes
- Smell alcohol
- Unsteady movements
- Others

Note

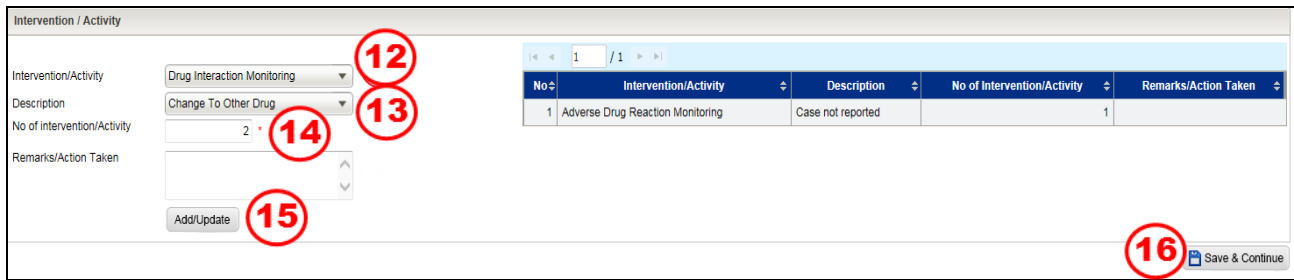
Blank fields will be enabled if user selects 'Other' from the drop down box of Evidence of withdrawal and Evidence of intoxication.

STEP 11

Select **Pharmacist remarks on current dose** from the drop down box

- Sufficient
- Too High
- Too Low

Intervention / Activity



The screenshot shows a web form titled "Intervention / Activity". On the left, there are several input fields: "Intervention/Activity" with a dropdown menu showing "Drug Interaction Monitoring" (callout 12), "Description" with a dropdown menu showing "Change To Other Drug" (callout 13), "No of Intervention/Activity" with a text input field containing "2" (callout 14), and "Remarks/Action Taken" with a text area (callout 15). Below these fields is an "Add/Update" button (callout 15). On the right, there is a table with the following data:

No	Intervention/Activity	Description	No of Intervention/Activity	Remarks/Action Taken
1	Adverse Drug Reaction Monitoring	Case not reported	1	

At the bottom right of the form is a "Save & Continue" button (callout 16).

Figure 3.2.3.6-5 Specific Details – Methadone

STEP 12

Select **Intervention / Activity** from the drop down box

- Adverse Drug Reaction Monitoring
- Drug Information
- Drug Interaction Monitoring
- Methadone Dose Modification
- Type of side affect

STEP 13

Select **Description** from the drop down box


STEP 14

Enter **No of Intervention/Activity**

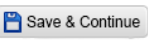
Note

Description will be according to the Intervention/Activity selected from the drop down box


STEP 15

Click on the  button to add drug information on the list

STEP 16

Click on the  button to save and continue with reporting record

STEP 17

Click on the  button to confirm save order

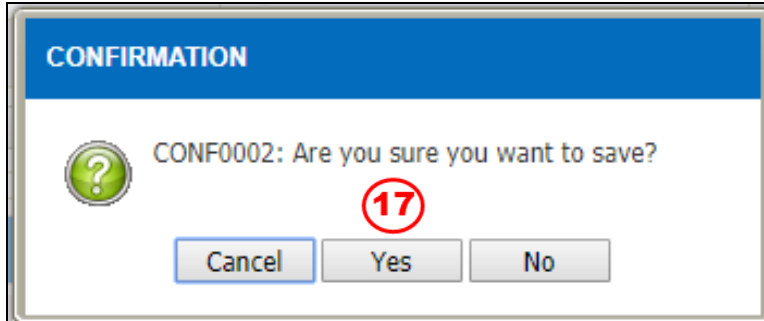


Figure 3.2.3.6-6 Confirmation Alert Message

STEP 18

Click on the  button to add record

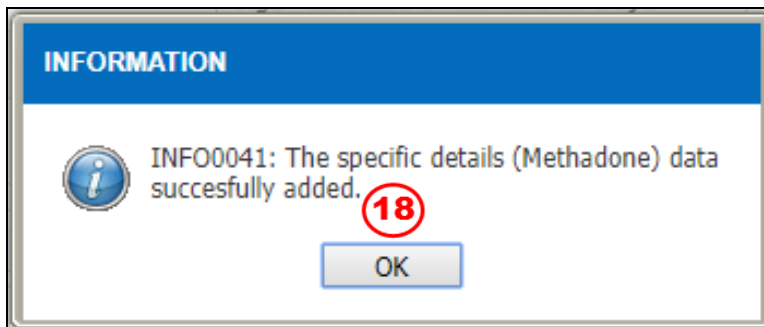


Figure 3.2.3.6-7 Information Alert Message

Note

For 'Reporting' section, repeat **Note (Page 28) to Step 32** as in 3.2.1 Create New MTAC Reporting with No Specific Details.

3.2.3.7 Renal Transplant

This function allow user to record Specific Details for Renal Transplant for MTAC patient.

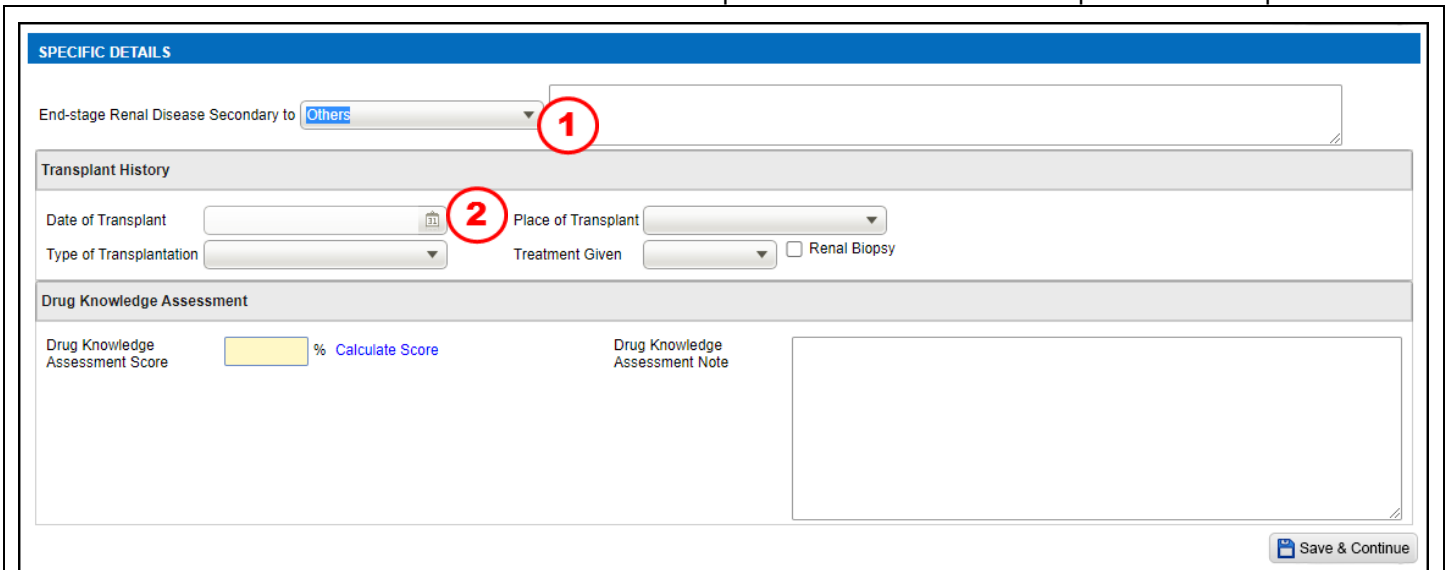


Figure 3.2.3.7-1 Specific Details - Renal Transplant

Note

Repeat **STEP 1 to 16** as in 3.2.1 Create New MTAC Reporting with No Specific Details before performing MTAC Reporting - Specific Details for Renal Transplant.

STEP 1

Select **End-stage Renal Disease Secondary to** from the drop down box


- Long Standing Hypertension
- Diabetic Nephropathy
- Lupus Nephritis
- Unknown
- Others

Note

Once selected **Others**, system will display free text field to fill in details

Transplant History

STEP 2

Click on the  button to select **Date of Transplant**

Select **Type of Transplantation** from the drop down box

- Cadaveric
- Living Non Related
- Living Related

Select **Place of Transplant** from the drop down box

- Local
- Overseas

Select **Treatment Given** from the drop down box

- Simulect
- OKT3
- Anti-Thymocyte

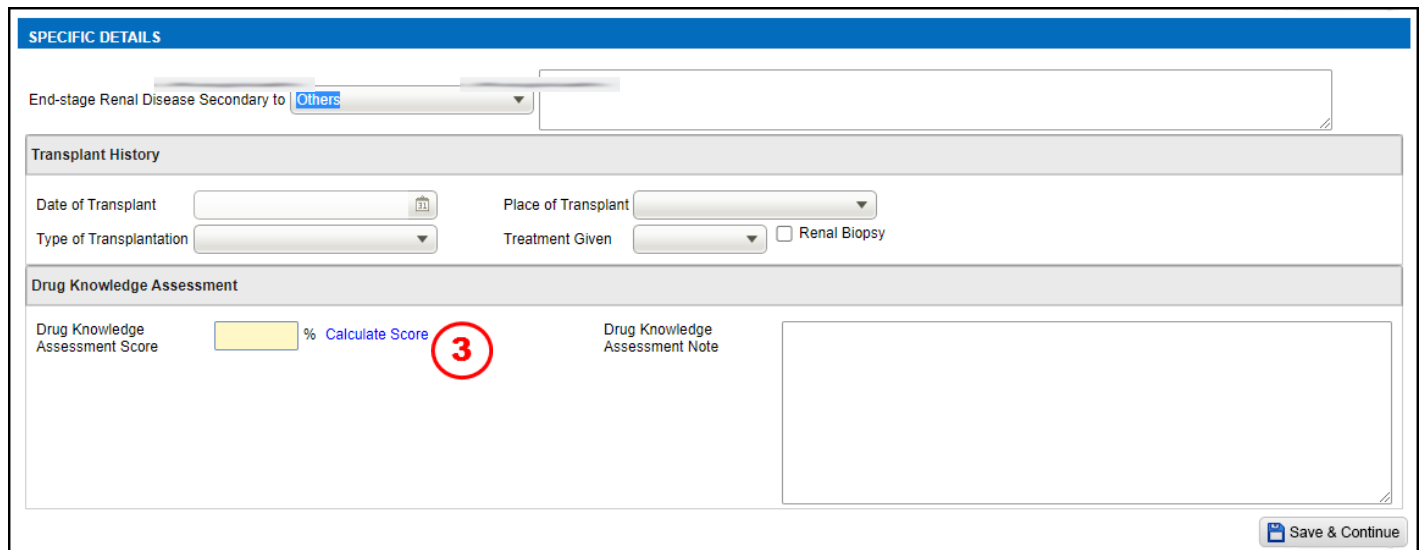
Note

User can check on the **Renal Biopsy** check box.

Drug Knowledge Assessment

STEP 3

Click on the [Calculate Score](#) hyperlink for **Drug Knowledge Assessment Score** and the 'Review of Patient's Understanding (Medication) DFIT' window will be displayed as shown in Figure 3.2.3.7-2




The screenshot shows a web form titled 'SPECIFIC DETAILS' for a Renal Transplant. It contains several input fields and buttons. The 'Drug Knowledge Assessment' section has a 'Calculate Score' button circled in red with the number 3. A 'Save & Continue' button is at the bottom right.

Figure 3.2.3.7-2 Specific Details - Renal Transplant

STEP 4

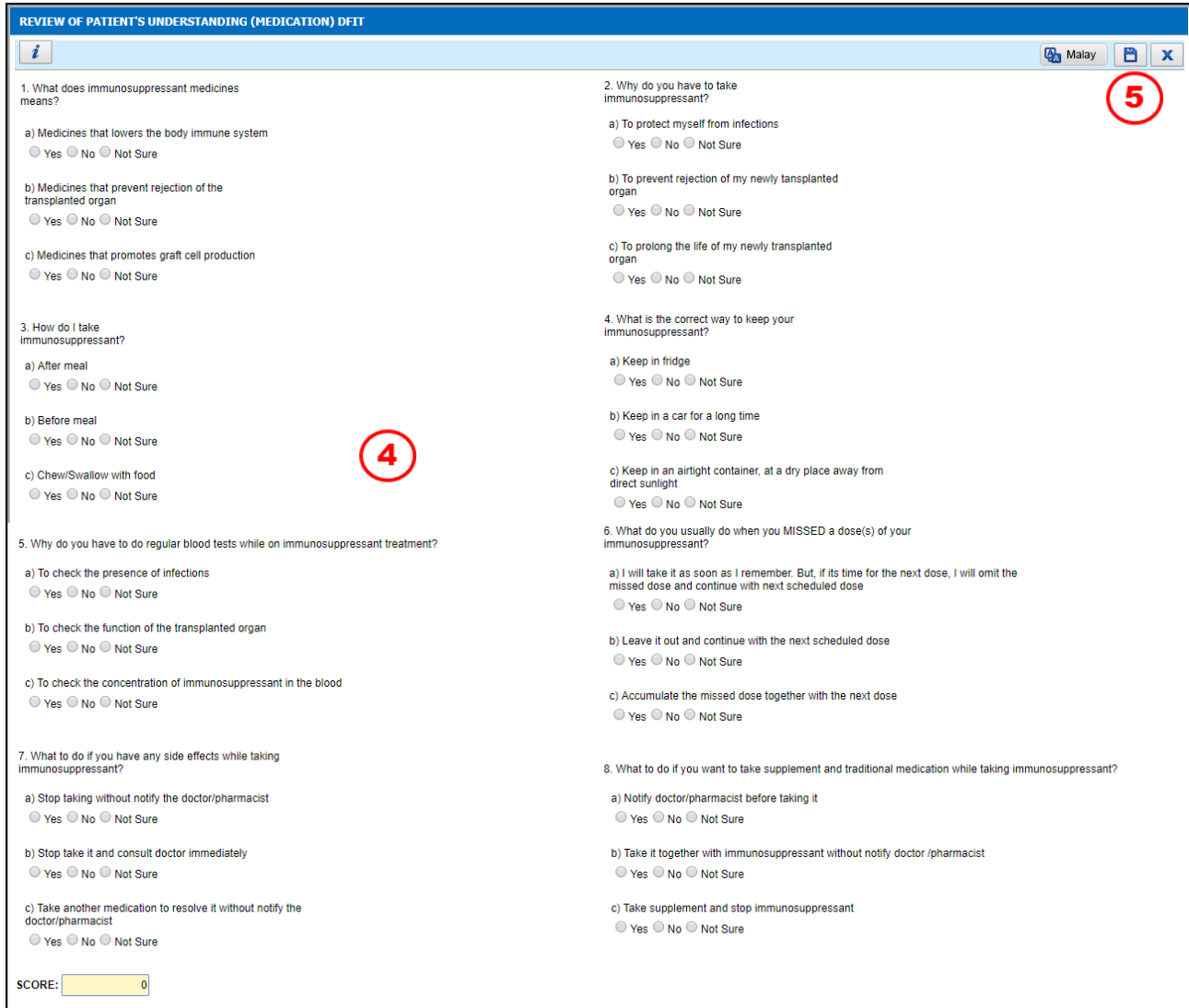
Answer all questionnaire in the **Review of Patient's Understanding** window by selecting the radio button to answer every questions

Note

- Click on the  button to view in Malay language.
- Score will be automatically calculated and automatically displayed

STEP 5

Click on the  button to save record



REVIEW OF PATIENT'S UNDERSTANDING (MEDICATION) DFIT

1. What does immunosuppressant medicines means?

- a) Medicines that lowers the body immune system
 Yes No Not Sure
- b) Medicines that prevent rejection of the transplanted organ
 Yes No Not Sure
- c) Medicines that promotes graft cell production
 Yes No Not Sure

2. Why do you have to take immunosuppressant?

- a) To protect myself from infections
 Yes No Not Sure
- b) To prevent rejection of my newly transplanted organ
 Yes No Not Sure
- c) To prolong the life of my newly transplanted organ
 Yes No Not Sure

3. How do I take immunosuppressant?

- a) After meal
 Yes No Not Sure
- b) Before meal
 Yes No Not Sure
- c) Chew/Swallow with food
 Yes No Not Sure

4. What is the correct way to keep your immunosuppressant?

- a) Keep in fridge
 Yes No Not Sure
- b) Keep in a car for a long time
 Yes No Not Sure
- c) Keep in an airtight container, at a dry place away from direct sunlight
 Yes No Not Sure

5. Why do you have to do regular blood tests while on immunosuppressant treatment?

- a) To check the presence of infections
 Yes No Not Sure
- b) To check the function of the transplanted organ
 Yes No Not Sure
- c) To check the concentration of immunosuppressant in the blood
 Yes No Not Sure

6. What do you usually do when you MISSED a dose(s) of your immunosuppressant?

- a) I will take it as soon as I remember. But, if its time for the next dose, I will omit the missed dose and continue with next scheduled dose
 Yes No Not Sure
- b) Leave it out and continue with the next scheduled dose
 Yes No Not Sure
- c) Accumulate the missed dose together with the next dose
 Yes No Not Sure

7. What to do if you have any side effects while taking immunosuppressant?

- a) Stop taking without notify the doctor/pharmacist
 Yes No Not Sure
- b) Stop take it and consult doctor immediately
 Yes No Not Sure
- c) Take another medication to resolve it without notify the doctor/pharmacist
 Yes No Not Sure


8. What to do if you want to take supplement and traditional medication while taking immunosuppressant?

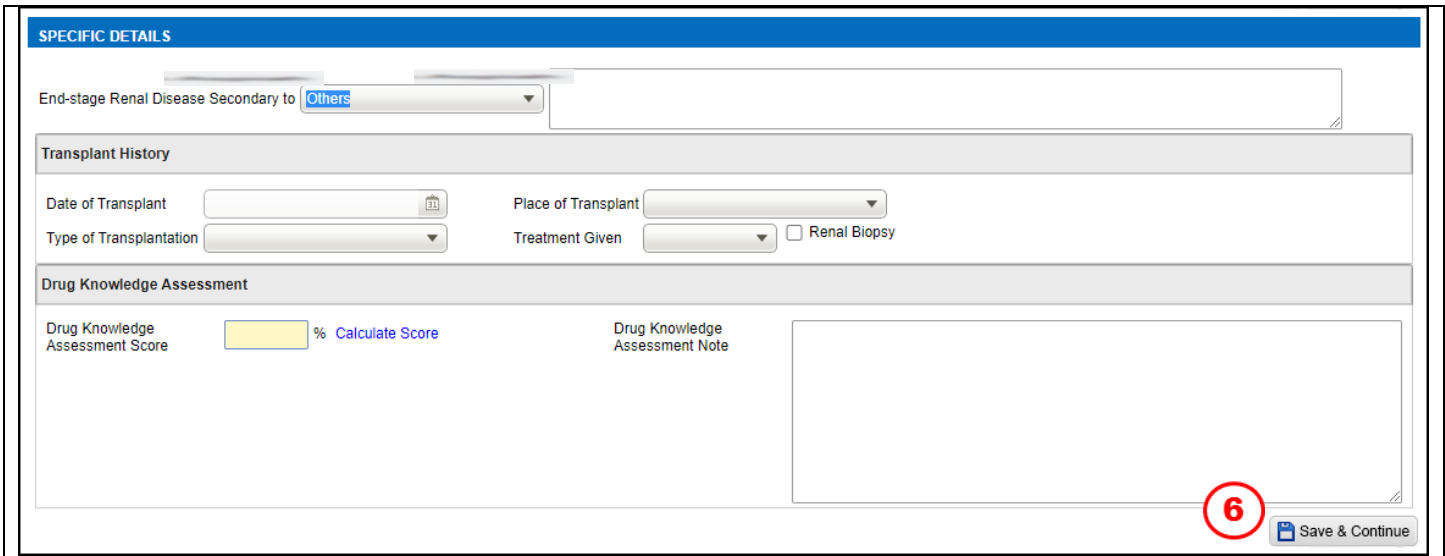
- a) Notify doctor/pharmacist before taking it
 Yes No Not Sure
- b) Take it together with immunosuppressant without notify doctor /pharmacist
 Yes No Not Sure
- c) Take supplement and stop immunosuppressant
 Yes No Not Sure

SCORE:

Figure 3.2.3.7-3 Drug Knowledge Assessment

STEP 6

Click on the  button as shown in Figure 3.2.3.7-4 to save and continue with reporting section



SPECIFIC DETAILS

End-stage Renal Disease Secondary to

Transplant History

Date of Transplant Place of Transplant

Type of Transplantation Treatment Given Renal Biopsy

Drug Knowledge Assessment

Drug Knowledge Assessment Score % Drug Knowledge Assessment Note

6

Figure 3.2.3.7-4 Specific Details - Renal Transplant

STEP 7

Click on the button to confirm save record

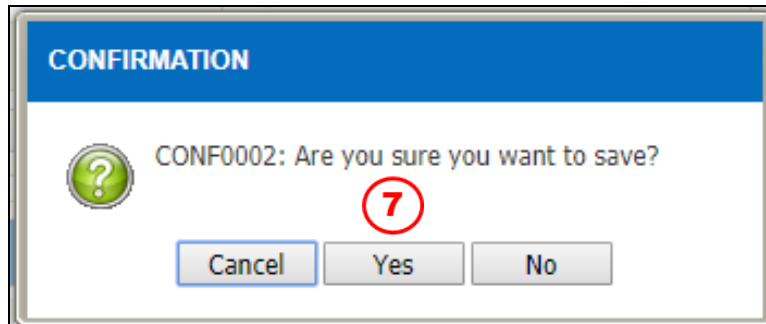


Figure 3.2.3.7-5 Confirmation Alert Message

STEP 8

Click on the button to confirm record

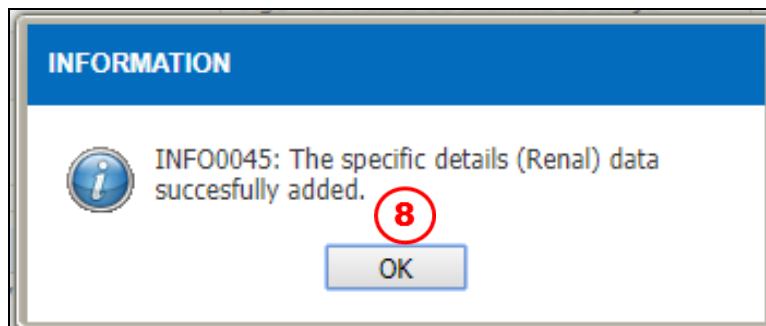


Figure 3.2.3.7-6 Information Alert Message

Note

For 'Reporting' section, repeat **Note (Page 28) to Step 32** as in 3.2.1 Create New MTAC Reporting with No Specific Details.

3.2.3.8 Respiratory

This function allow user to record Specific Details for Respiratory for MTAC patient

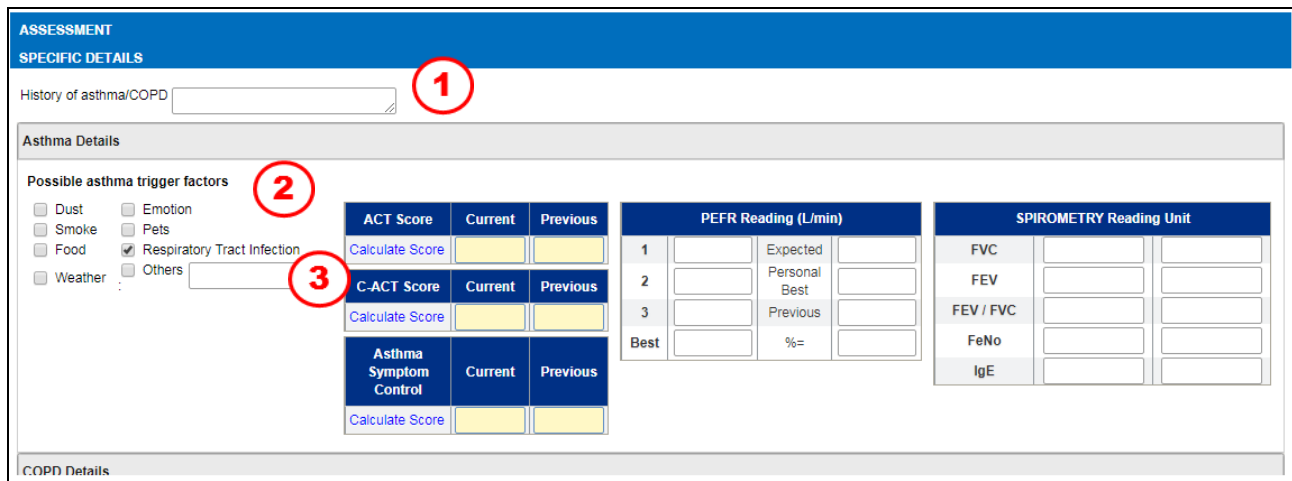


Figure 3.2.3.8-1 Specific Details – Respiratory Details

Note

Repeat **STEP 1 to 16** as in 3.2.1 Create New MTAC Reporting with No Specific Details before performing MTAC Reporting - Specific Details for Respiratory

STEP 1

Enter **History of asthma/COPD**

Asthma Details

STEP 2

Select **Possible asthma trigger factors** from the check box. User is allowed to select more than one (1)

- Dust
- Smoke
- Food
- Weather
- Emotion
- Pets
- Respiratory Tract Infection
- Others

Note

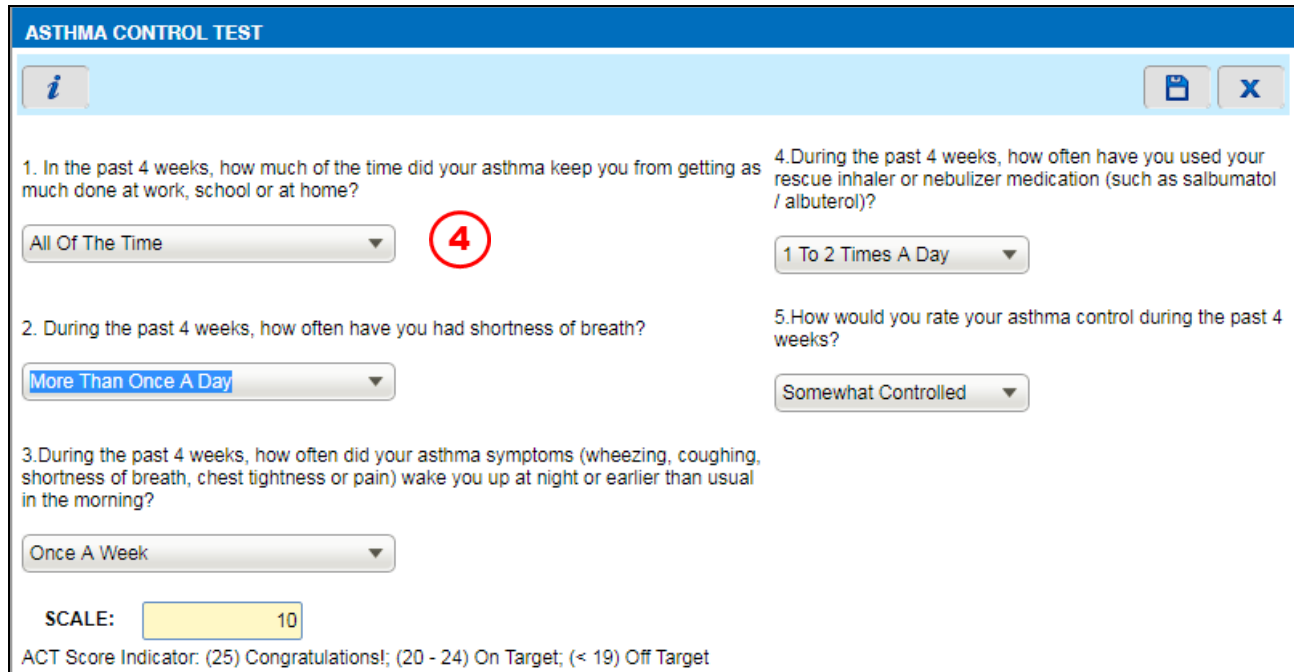
Blank field will be enabled only if user selects 'Others' from the check box.

STEP 3

Click on the [Calculate Score](#) hyperlink for **ACT Score**, **C-ACT Score** and the '**Asthma Symptom Control**', window will be displayed as shown in Figure 3.2.3.8-2 (a), Figure 3.2.3.8-2 (b), Figure 3.2.3.8-2 (c)

STEP 4

Select the drop down box to answer the questionnaire



ASTHMA CONTROL TEST

1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or at home?
All Of The Time

2. During the past 4 weeks, how often have you had shortness of breath?
More Than Once A Day

3. During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?
Once A Week

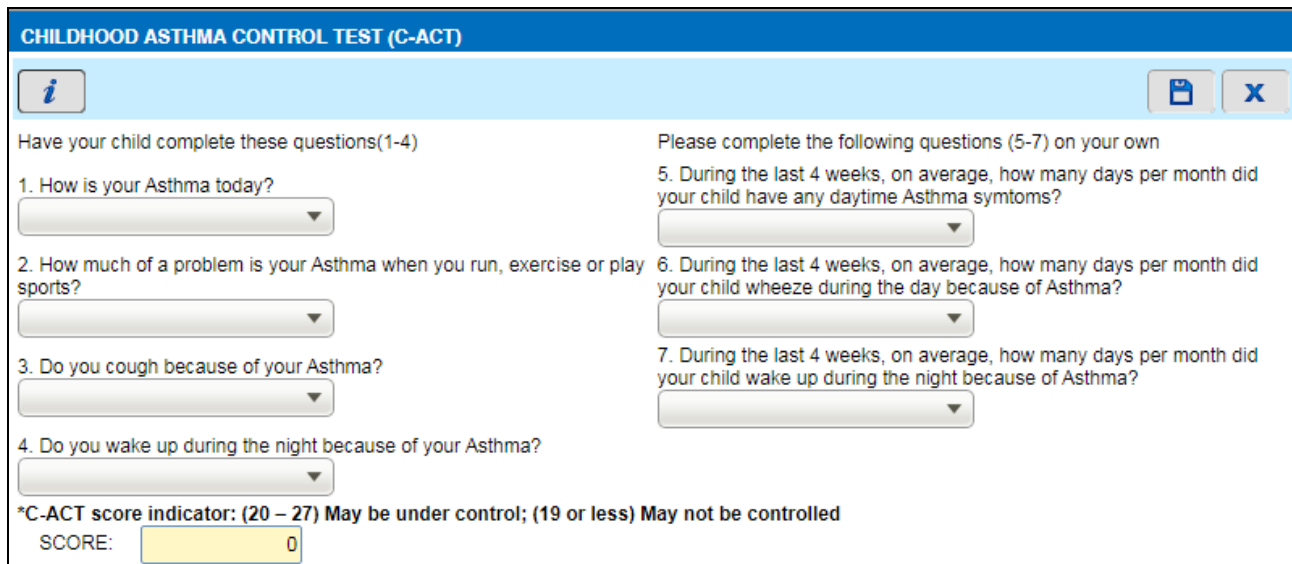
4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as salbutamol / albuterol)?
1 To 2 Times A Day

5. How would you rate your asthma control during the past 4 weeks?
Somewhat Controlled

SCALE: 10

ACT Score Indicator: (25) Congratulations!; (20 - 24) On Target; (< 19) Off Target

Figure 3.2.3.8-2 (a) Asthma Control Test – Questionnaire



CHILDHOOD ASTHMA CONTROL TEST (C-ACT)

Have your child complete these questions(1-4)

1. How is your Asthma today?

2. How much of a problem is your Asthma when you run, exercise or play sports?

3. Do you cough because of your Asthma?

4. Do you wake up during the night because of your Asthma?

Please complete the following questions (5-7) on your own

5. During the last 4 weeks, on average, how many days per month did your child have any daytime Asthma symptoms?

6. During the last 4 weeks, on average, how many days per month did your child wheeze during the day because of Asthma?

7. During the last 4 weeks, on average, how many days per month did your child wake up during the night because of Asthma?

*C-ACT score indicator: (20 – 27) May be under control; (19 or less) May not be controlled

SCORE: 0

Figure 3.2.3.8-2 (b) Childhood Asthma Control Test – Questionnaire

ASTHMA SYMPTOM CONTROL

i
X

[Record the Level of Asthma Symptom Control Scale at each visit. In the past 4 weeks, has the patient had (please (✓) for Yes ; (X) for No)]

1. Daytime symptoms more than twice/week?	Yes	▼
2. Any night waking due to Asthma?	No	▼
3. Reliever needed* more than twice/week	Yes	▼
4. Any activity limitation due to Asthma?	Yes	▼

#Level of Asthma Symptom Control scale indicator:
 (1) Controlled: None of these items;
 (2) Partly Controlled: 1-2 of these items;
 (3) Uncontrolled: 3-4 of these items

SCALE:

Figure 3.2.3.8-2 (c) Asthma Symptom Control – Questionnaire

Note

Score will be automatically calculated and automatically displayed.

STEP 5

Click on the [Calculate Score](#) hyperlink and window of 'CAT Score – Questionnaire' will be display as per Figure 3.2.3.8-3

COPD Details

CAT Score	CAT Score	Current	Previous
Calculate Score	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>

Inhaler Technique Checklist

[+ Add](#)

Inhaler Technique	Before Counselling	After Counselling	
Accuhaler Score	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	Calculate Score
Accuhaler Score			
Breezhaler Score			
Easyhaler Score			
Ellipta Score			
Handihaler Score			
MDI Score			
MDI and Aerochamber Score			
MDI and Optichamber Score			
MDI and Tube Score			
Respiimat Score			
Turbuhaler Score			

[Save & Continue](#)

Figure 3.2.3.8-3 Specific Details – COPD Details

STEP 6

Select **CAT Score – Questionnaire** check box and save record

CAT SCORE - QUESTIONNAIRE

6

1. I never cough 0 1 2 3 4 5 I cough all the time

2. I have no phlegm (mucus) in my chest at all 0 1 2 3 4 5 My chest is completely full of phlegm (mucus)

3. My chest does not feel tight at all 0 1 2 3 4 5 My chest feels very tight

4. When I walk up a hill or one flight of stairs I am not breathless 0 1 2 3 4 5 When I walk up a hill or one flight of stairs I am very breathless

5. I am not limited doing any activities at home 0 1 2 3 4 5 I am very limited doing activities at home

6. I am confident leaving my home despite my lung condition 0 1 2 3 4 5 I am not at all confident leaving my home because of my lung condition

7. I sleep soundly 0 1 2 3 4 5 I don't sleep soundly because of my lung condition

8. I have lots of energy 0 1 2 3 4 5 I have no energy at all

SCALE:

CAT Score Indicator: (<10) = Low Impact; (10-20) = Medium Impact; (> 20) = High Impact; (>30) = Very High Impact

Figure 3.2.3.8-4 CAT Score – Questionnaire

STEP 7

Click on the [Calculate Score](#) hyperlink of Inhaler Technic Before and After Counseling to do questionnaire as below:

- a) MDI Score
- b) Easyhaler Score
- c) MDI and Aerochamber Score
- d) MDI and TUBE Score
- e) MDI and Optichamber Score
- f) Turbuhaler Score
- g) Accuhaler Score
- h) Handihaler Score
- i) Breezhaler Score
- j) Respimat Score
- k) Ellipta Score

EASYHALER - EVALUATION

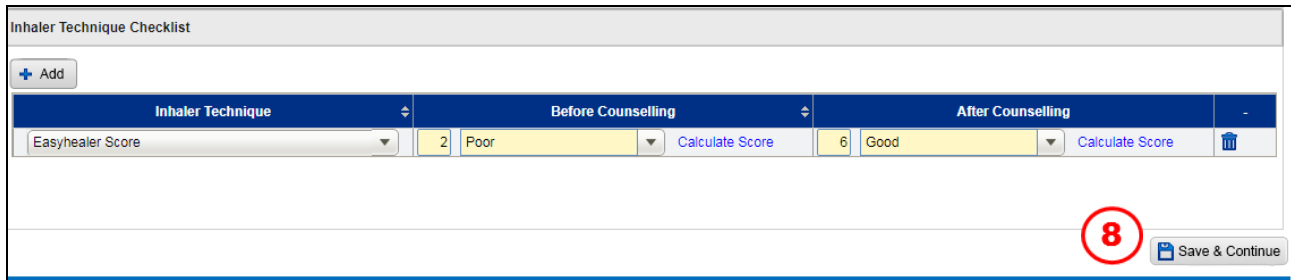
Indicate YES (1) or NO (0) if step was performed in proper sequences;
if critical step (**) falls under NO (0), overall technique is poor.

No	Question	Answer
1.	Remove the dust cap and shake easyhaler in an up-down motion 3-5 times.	<input type="radio"/> Yes <input checked="" type="radio"/> No
2.	Hold the device in upright position. Press easyhaler ONCE until a 'CLICK' sound is heard	<input type="radio"/> Yes <input checked="" type="radio"/> No
3.	Breath out completely, away from the mouthpiece.	<input checked="" type="radio"/> Yes <input type="radio"/> No
4.	Place mouthpiece between lips. Make sure lips cover the mouthpiece tightly. Inhale forcefully and deeply through the mouth**.	<input checked="" type="radio"/> Yes <input type="radio"/> No
5.	Remove the inhaler from the mouth and hold breath for 5-10 seconds, and then breath out slowly.	<input type="radio"/> Yes <input checked="" type="radio"/> No
6.	Repeat step 1-5 if more than one dose is required.	<input type="radio"/> Yes <input checked="" type="radio"/> No

Score Rating: (6) Good, (4 - 5) Satisfactory, (0 - 3) Poor

SCALE:

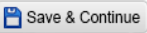
Figure 3.2.3.8-5(a) Inhaler Technique Understanding-Before



Inhaler Technique	Before Counselling	After Counselling	
Easyhealer Score	2 Poor Calculate Score	6 Good Calculate Score	Save & Continue

Figure 3.2.3.8-5(b) Inhaler Technique Understanding-After

STEP 8

Click on the  button as shown in Figure 3.2.3.8-5 to save and continue with reporting section

STEP 9

Click on the  button to confirm save order

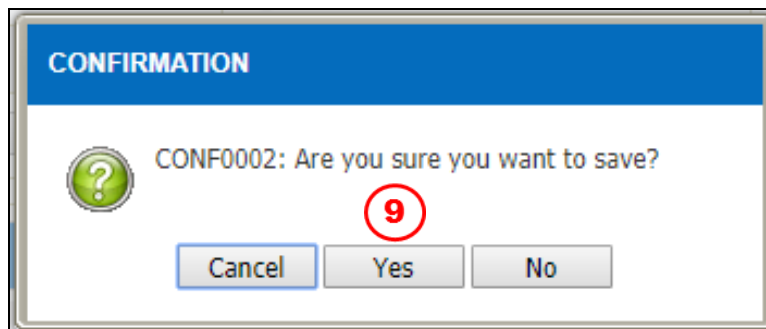



Figure 3.2.3.8-6 Confirmation Alert Message

STEP 10

Click on the  button to confirm record

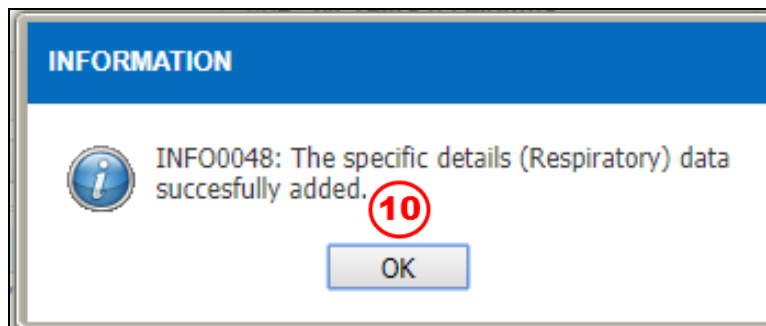


Figure 3.2.3.8-7 Information Alert Message

Note

For 'Reporting' section, repeat **Note (Page 28) to Step 32** as in 3.2.1 Create New MTAC Reporting with No Specific Details.

3.2.3.9 Retro Viral Disease

This function allows users to record Specific Details for Retro Vital Disease for MTAC patients.

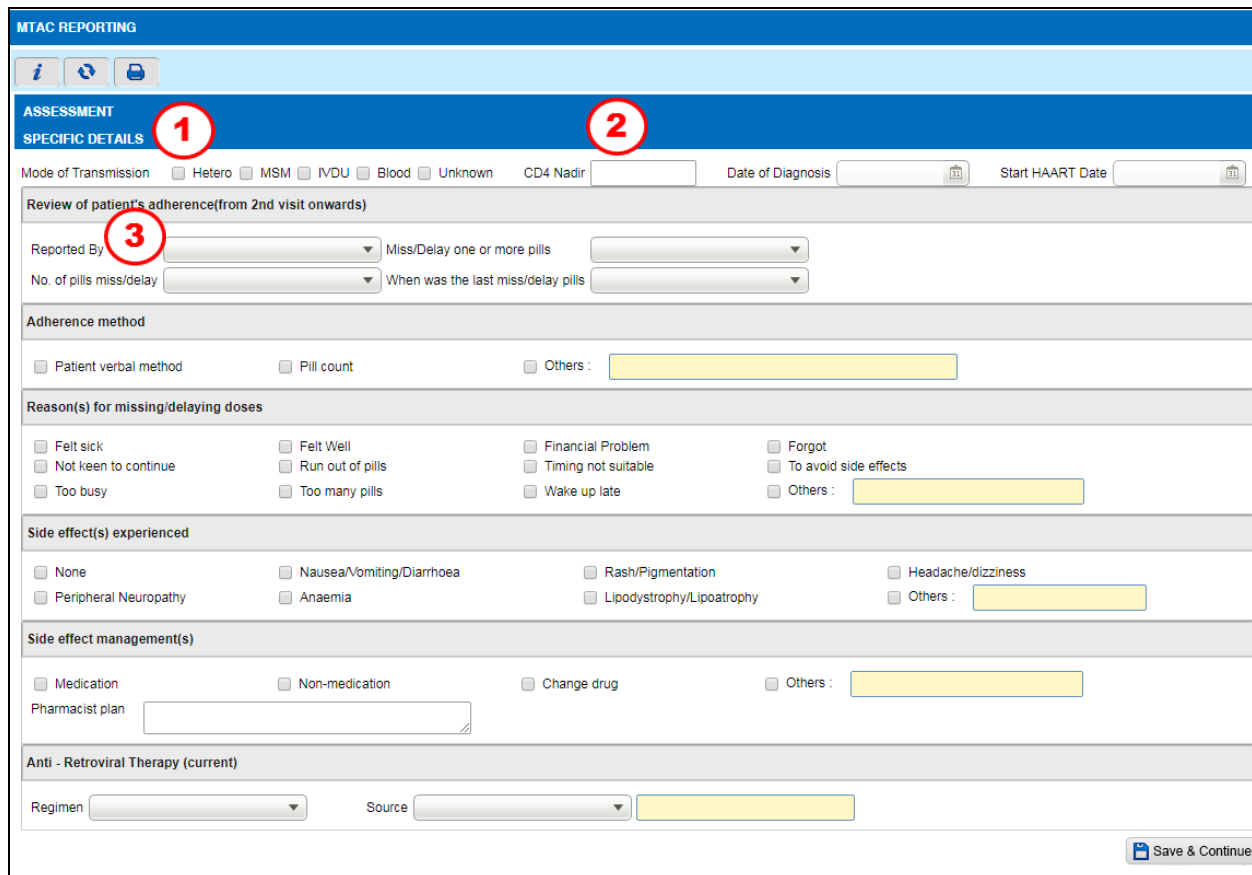


Figure 3.2-3.9-1 Specific Details - Retro Viral Disease

Note

Repeat **Step 1 to Step 16** as in 3.2.1 Create New MTAC Reporting with No Specific Details before performing MTAC Reporting - Specific Details for Retro Viral Disease.

STEP 1

Select **Mode of Transmission** from the check box

- Hetero
- MSM
- IVDU
- Blood
- Unknown

STEP 2

Enter **CD4 Nadir**

Review of patient's adherence (from 2nd visit onwards)

STEP 3

Select **Reported By** from the drop down box

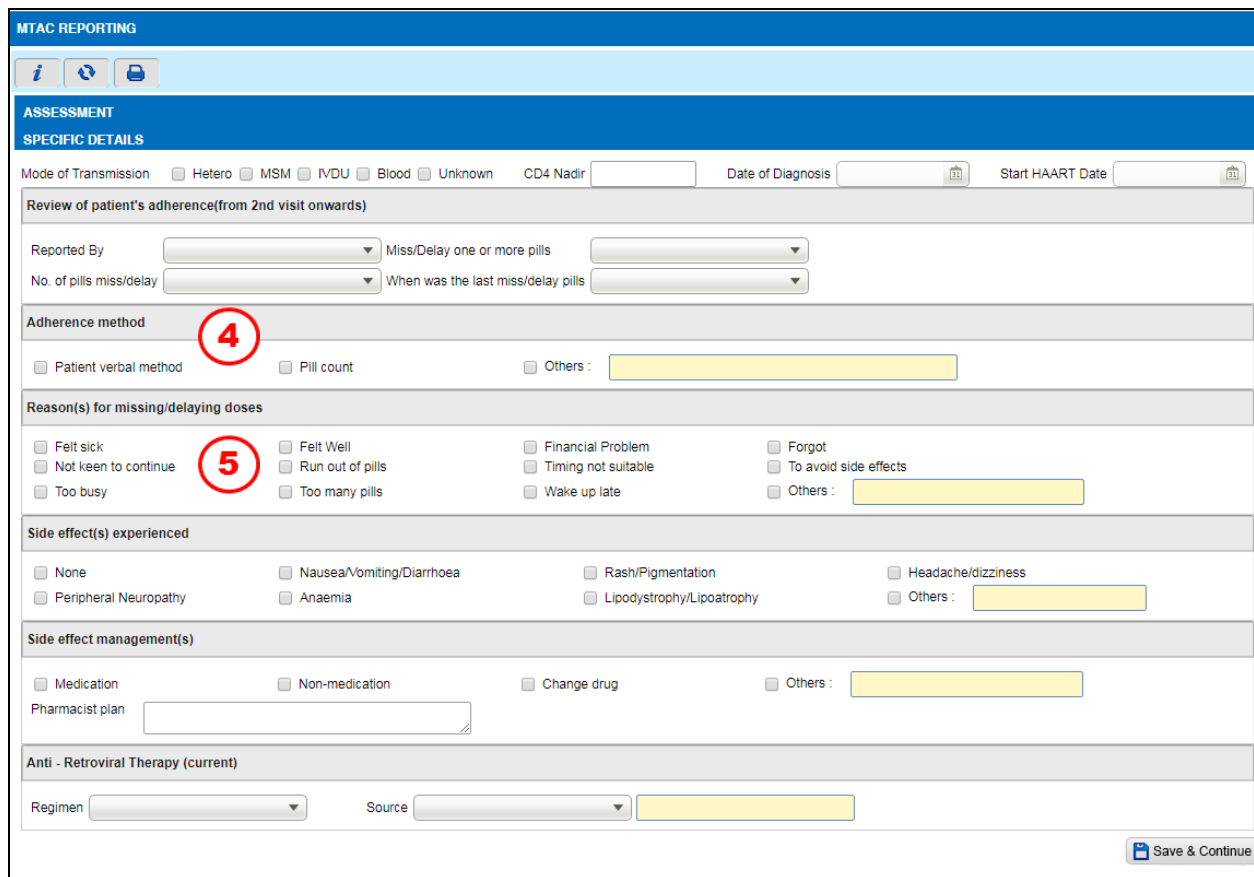
- Caregiver
- Patient

Select **Miss/Delay one or more pills** from the drop down box

- Yes
- No

Note

No. of pills miss/delay and when was the last miss/delay pills will be enabled only if user selects 'Yes' from the **Miss/Delay one or more pills** drop down box



MTAC REPORTING

ASSESSMENT

SPECIFIC DETAILS

Mode of Transmission Hetero MSM IVDU Blood Unknown CD4 Nadir Date of Diagnosis Start HAART Date

Review of patient's adherence(from 2nd visit onwards)

Reported By Miss/Delay one or more pills

No. of pills miss/delay When was the last miss/delay pills

Adherence method 4

Patient verbal method Pill count Others :

Reason(s) for missing/delaying doses 5

Felt sick Felt Well Financial Problem Forgot

Not keen to continue Run out of pills Timing not suitable To avoid side effects

Too busy Too many pills Wake up late Others :

Side effect(s) experienced

None Nausea/Vomiting/Diarrhoea Rash/Pigmentation Headache/dizziness

Peripheral Neuropathy Anaemia Lipodystrophy/Lipoatrophy Others :

Side effect management(s)

Medication Non-medication Change drug Others :

Pharmacist plan

Anti - Retroviral Therapy (current)

Regimen Source

Figure 3.2.3.9-2 Specific Details - Retro Viral Disease

STEP 4

Select **Adherence Method** from the check box

- Patient verbal method

- Pill count
- Others

Note

Blank field will be enabled if user selects 'Others' from the check box.

STEP 5

Select **Reason(s) for missing/delaying doses** from the check box

- Forgot
- Felt Well
- Wake up late
- Too many pills
- To avoid side effects
- Timing not suitable
- Too busy
- Financial Problem
- Run out of pills
- Felt sick
- Not keen to continue
- Others

Note

Blank field will be enabled if user selects 'Others' from the check box.

SPECIFIC DETAILS

Mode of Transmission Hetero MSM IVDU Blood Unknown CD4 Nadir Date of Diagnosis Start HAART Date

Review of patient's adherence(from 2nd visit onwards)

Reported By Miss/Delay one or more pills

No. of pills miss/delay When was the last miss/delay pills

Adherence method

Patient verbal method Pill count Others :

Reason(s) for missing/delaying doses

Felt sick Felt Well Financial Problem Forgot
 Not keen to continue Run out of pills Timing not suitable To avoid side effects
 Too busy Too many pills Wake up late Others :

Side effect(s) experienced **6**

None Nausea/Vomiting/Diarrhoea Rash/Pigmentation Headache/dizziness
 Peripheral Neuropathy Anaemia Lipodystrophy/Lipoatrophy Others :

Side effect management(s) **7**

Medication Non-medication Change drug Others :

Pharmacist plan

Anti - Retroviral Therapy (current) **8**

Regimen Source **9**

Figure 3.2.3.9-3 Specific Details - Retro Viral Disease

STEP 6

Select **Side effect(s) experienced** from the check box

- None
- Peripheral Neuropathy
- Nausea/Vomiting/Diarrhoea
- Anaemia
- Rash/Pigmentation
- Lipodystrophy/Lipoatrophy
- Headache/dizziness
- Others

Note

Blank field will be enabled if user selects 'Others' from the check box.

STEP 7

Select **Side effect management(s)** from the check box

- Medication
- Non-medication
- Change drug

- Others

Note

Blank field will be enabled if user selects 'Others' from the check box

Enter **Pharmacist plan** if necessary

Anti-Retroviral Therapy (current)

STEP 8

Select **Regimen** from the drop down box

- 1st line
- 2nd line
- 3rd line

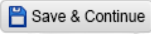
Select **Source** from the drop down box

- Baitulmal
- Charity fund
- Hospital
- NGO
- Others
- Self
- UNHCR

Note

Blank field will be enabled if user selects 'Others' from the check box.

STEP 9

Click on the  button as shown in Figure 3.2.3.9-3 to save and continue with reporting section

STEP 10

Click on the  button to confirm save record

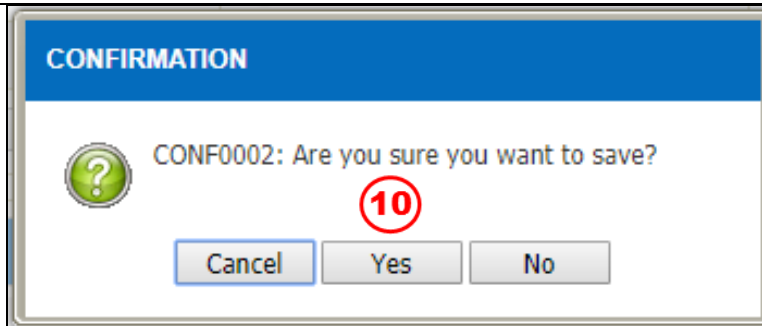



Figure 3.2.3.9-4 Confirmation Alert Message

STEP 11

Click on the  button to confirm record

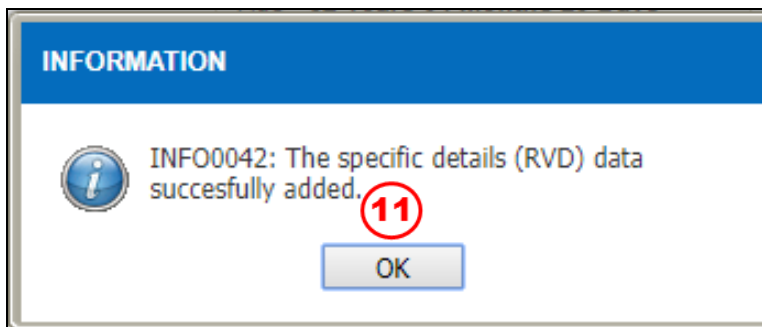


Figure 3.2.3.9-5 Information Alert Message

Note

For 'Reporting' section, repeat **Note (Page 28) to Step 32** as in 3.2.1 Create New MTAC Reporting with No Specific Details.

3.2.3.10 Warfarin

This function allow user to record Specific Details for Warfarin for MTAC patients.

Figure 3.2.3.10-1- MTAC Order-Warfarin

Figure 3.2.3.10-2 Specific Details - Warfarin

Note

- Repeat **STEP 1 to 16** as in 3.2.1 Create New MTAC Reporting with No Specific Details before performing MTAC Reporting - Specific Details for Warfarin.
- Additional **Time in Therapeutic Range(TTR)** function added as per Figure 3.2.3.10-1 and will display in specific details as per Figure 3.2.3.10-2

STEP 1

For **Subjective Information**, select 'Yes' or 'No' radio buttons for below:

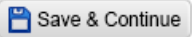
- **Signs of bleeding**
- **Correct Dose Taken**
- **Signs of thrombosis**

- **Missed doses in past 1 week**
- **Medication changes**
- **Changes in Medical Status/Illness**
- **Other complaint/patient plans**
- **Change in Physical Activity**

Note

- Enter remark (if available) and dosage for **Correct Dose Taken** at the blank field provided
- **Total weekly dose, Target INR Range, Warfarin Indication, Bleeding Risk Factor, Date Warfarin Started and Anticipated Duration** will be automatically displayed based on what user key in in MTAC order details as shown in Figure 3.2.3.10-2.
- User is allowed to fill in the recommended warfarin dose per day in the column below as shown in Figure 3.2.3.10-2.

STEP 2

Click on the  button to save and continue with reporting section

STEP 3

Click on the  button to confirm save record

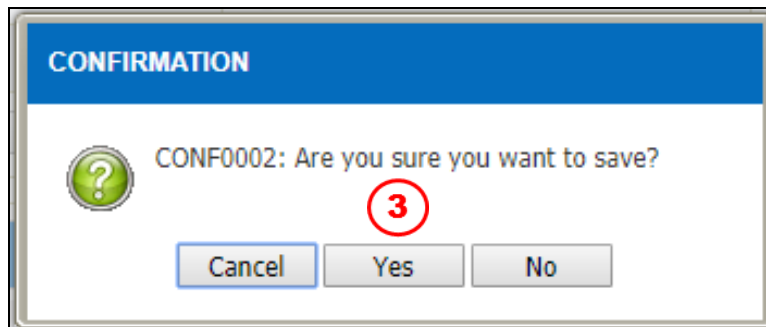


Figure 3.2.3.10-3 Confirmation Alert Message

STEP 4

Click on the  button to confirm record

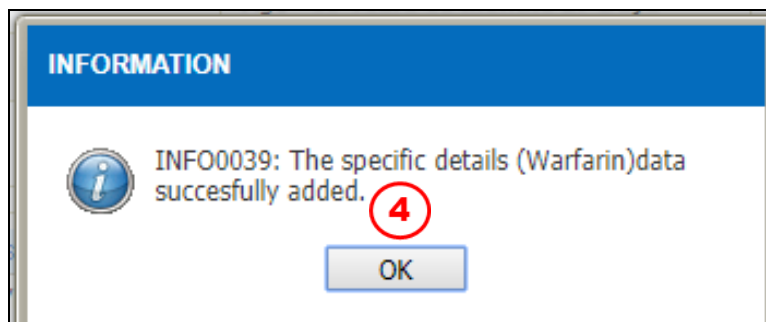


Figure 3.2.3.10-4 Information Alert Message

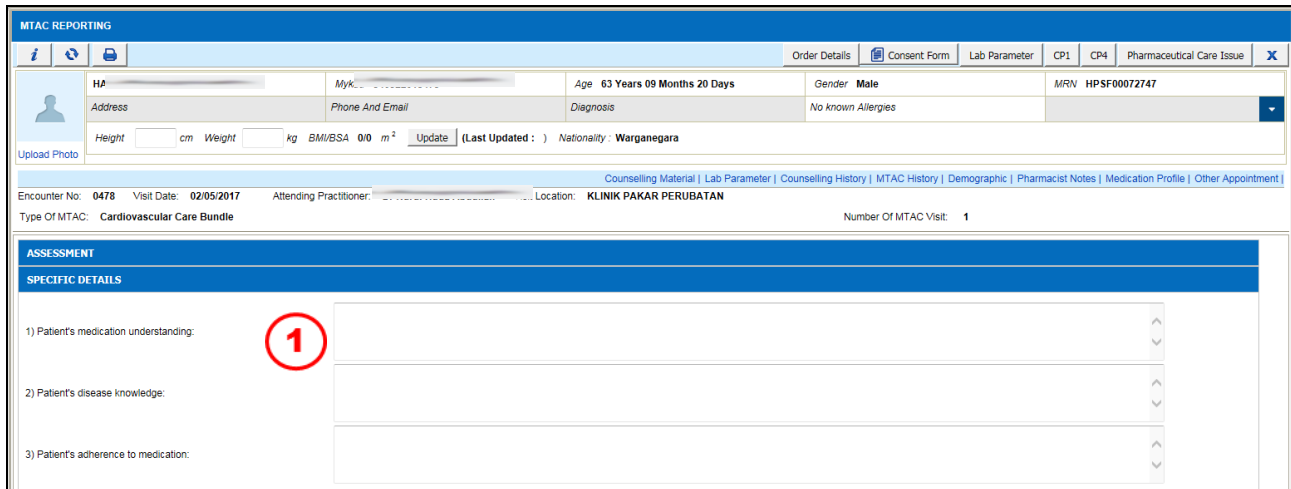


Note

- For 'Reporting' section, repeat **Note (Page 28) to Step 32** as in 3.2.1 Create New MTAC Reporting with No Specific Details.
- If patient has previous history, Target INR will appear in MTAC History

3.2.3.11 Cardiovascular Care Bundle

This function allow user to record Specific Details for Cardiovascular Care Bundle for MTAC patients.



The screenshot displays the 'MTAC REPORTING' interface. At the top, there are navigation tabs: 'Order Details', 'Consent Form', 'Lab Parameter', 'CP1', 'CP4', and 'Pharmaceutical Care Issue'. Below this, a patient information form includes fields for HA, Myk..., Age (63 Years 09 Months 20 Days), Gender (Male), MRN (HPSF00072747), Address, Phone And Email, Diagnosis, No known Allergies, Height, Weight, BMI/BSA (0/0 m²), and Nationality (Warganegara). A 'Counselling Material' section is also visible. The 'ASSESSMENT' section is expanded to show 'SPECIFIC DETAILS' with three text input areas: '1) Patient's medication understanding:', '2) Patient's disease knowledge:', and '3) Patient's adherence to medication:'. A red circle with the number '1' is placed over the first input area.

Figure 3.2.3.11-1 Specific Details – Cardiovascular Care Bundle

Note

Repeat **STEP 1 to 16** as in 3.2.1 Create New MTAC Reporting with No Specific Details before performing MTAC Reporting - Specific Details for Warfarin.

STEP 1

For **Subjective Information**, user need to fill up the patient specific detail based on:

- **Patient medication understanding**
- **Patient disease knowledge**
- **Patient adherence to medication**

Note

- For 'Reporting' section, repeat **Note (Page 28) to Step 32** as in 3.2.1 Create New MTAC Reporting with No Specific Details.
- User can save the specific detail after doing reporting part.

3.2.3.11 Haemophilia

This function allow user to record Specific Details for Haemophilia for MTAC patients.

Type Of MTAC: **Haemophilia** Number Of MTAC Visit: **1**

Bleeding patterns or frequency in the past **week(s) :**

1) Frequency of bleedings : times in a : week month

2) Type of bleed : Spontaneous Traumatic

3) Site of bleed (state all location)& frequency :

4) Time from bleed to infusion of factors : mins hrs

5) Time to alleviate pain/stop bleed : mins hrs

6) No. of infusions required to stop each bleeding incident :

7) No. of days off work/school : days

8) Prophylaxis dose (if applicable) : 1

History of serious bleed : No Yes

Intracranial bleed; Date :

Iliopsoas bleed; Date :

Others :

Date :

Target joints :

Deformities :

Education topics done : Visit 1 (C:1-7) Visit 2 (C:8-12) Visit 3 (C:13-16) Visit 4 (C:17-18)

Factor Concentrates Infusion Plan

On Demand Therapy

For bleeding in joint and/or muscles :-

% Target : Infuse vials of units factor concentrates when necessary.

Repeat after hours if necessary. 2

For bleeding in head, throat, GI and/or Iliopsoas :-

% Target : Infuse vials of units factor concentrates immediately and go to nearest haemophilia center.

Prophylaxis Therapy

% Target : Infuse vials of units factor concentrates and when necessary. 3

and when necessary.

Figure 3.2.3.11-1 Specific Details – Haemophilia

Note

Repeat **STEP 1 to 16** as in 3.2.1 Create New MTAC Reporting with No Specific Details before performing MTAC Reporting - Specific Details for Haemophilia.

STEP 1

For Specific details, user need to fill up the patient specific detail based on:

- **Bleeding patterns or frequency in the past**
- **History of serious bleed**
- **Target joints**
- **Deformities**


- **Education topics done**

STEP 2

For Factor Concentrates Infusion Plan, user need to fill up the patient specific detail based on:

- **On Demand Therapy**
- **Prophylaxis Therapy**

STEP 3

Click on the  button to save and continue with reporting section

STEP 4

Click on the  button to confirm save record

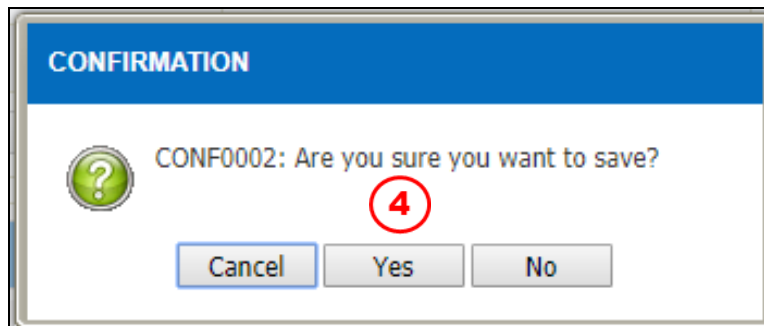


Figure 3.2.3.11-2 Confirmation Alert Message

STEP 5

Click on the  button to confirm record

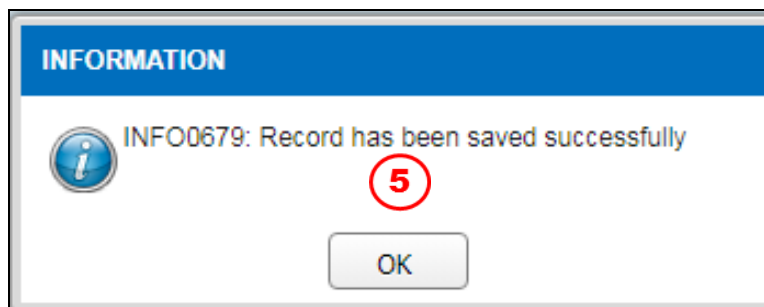


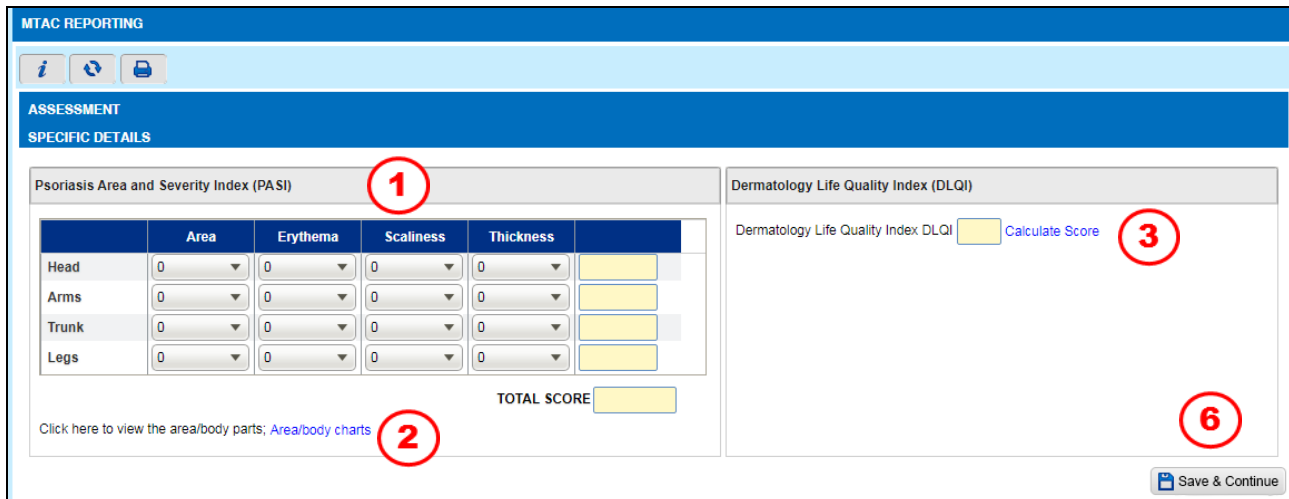
Figure 3.2.3.11-3 Information Alert Message

Note

- For 'Reporting' section, repeat **Note (Page 28) to Step 32** as in 3.2.1 Create New MTAC Reporting with No Specific Details.
- If patient has previous history, Haemophilia record will appear in MTAC History

3.2.3.12 Psoriasis

This function allow user to record Specific Details for Psoriasis for MTAC patients.



	Area	Erythema	Scaliness	Thickness	
Head	0	0	0	0	
Arms	0	0	0	0	
Trunk	0	0	0	0	
Legs	0	0	0	0	

TOTAL SCORE

Click here to view the area/body parts; [Area/body charts](#)

Dermatology Life Quality Index DLQI Calculate Score

Save & Continue

Figure 3.2.3.12-1 Specific Details – Psoriasis

Note

Repeat **STEP 1 to 16** as in 3.2.1 Create New MTAC Reporting with No Specific Details before performing MTAC Reporting - Specific Details for Psoriasis

1) Psoriasis Area Severity Index (PASI): Assessment

STEP 1

Select the score from drop down value for Area, Erythema, Scaliness and Thickness for:

- Head
- Arms
- Trunk
- Legs

Details calculation for the Psoriasis Area and Severity Index (PSAI) is as below:

No.	Name	Description
1.	Head (Area)	User can select from Drop down menu value = (0 – 6)
2.	Head (Erythema)	User can select from Drop down menu value = (0 – 6)
3.	Head (Scaliness)	User can select from Drop down menu value = (0 – 6)
4.	Head (Thickness)	User can select from Drop down menu value = (0 – 6)
5.	Head (Total)	Auto calculated based on below: 0.1 x Head Area x (Head Erythema + Head Scaliness + Head Thickness)
6.	Arms (Area)	User can select from Drop down menu value = (0 – 4)
7.	Arms (Erythema)	User can select from Drop down menu value = (0 – 4)
8.	Arms (Scaliness)	User can select from Drop down menu value = (0 – 4)
9.	Arms (Thickness)	User can select from Drop down menu value = (0 – 4)
10.	Arms (Total)	Auto calculated based on below: 0.2 x Arms Area x (Arms Erythema + Arms Scaliness + Arms Thickness)
11.	Trunk (Area)	User can select from Drop down menu value = (0 – 4)
12.	Trunk (Erythema)	User can select from Drop down menu value = (0 – 4)
13.	Trunk (Scaliness)	User can select from Drop down menu value = (0 – 4)
14.	Trunk (Thickness)	User can select from Drop down menu value = (0 – 4)
15.	Trunk (Total)	Auto calculated based on below: 0.3 x Trunk Area x (Trunk Erythema + Trunk Scaliness + Trunk Thickness)
16.	Legs (Area)	User can select from Drop down menu value = (0 – 4)
17.	Legs (Erythema)	User can select from Drop down menu value = (0 – 4)
18.	Legs (Scaliness)	User can select from Drop down menu value = (0 – 4)
19.	Legs (Thickness)	User can select from Drop down menu value = (0 – 4)
20.	Legs (Total)	Auto calculated based on below: 0.4 x Legs Area x (Legs Erythema + Legs Scaliness + Legs Trunk Thickness)
21.	Total Score	Auto calculated based on below: Head Total + Arms Total + Trunk Total + Legs Total

Table 3.2.3.12-1 Specific Details – Psoriasis

STEP 2

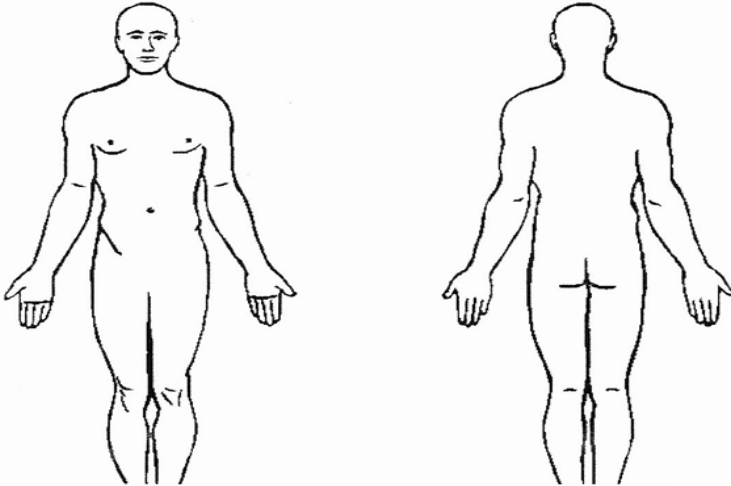
Click on the [Area/body charts](#) hyperlink to view the area/body parts :

MTAC PSORIASIS

Nama : EXXXX XXXXXXXX XXXXXXXXXX MRN : HKL000441 IC :

Tarikh : 09/08/2019 MTAC Visit : 1

Sila rujuk kepada warna atau nama ubat untuk memastikan ubat disapu pada bahagian badan yang betul



PSORIASIS AREA AND SEVERITY INDEX (PASI) : ASSESSMENT

E.g. 0.1 x Head Area x (Head Erythema + Head Scaliness + Head Thickness)

Head	: 0.1 x	1	x (	2	+	0	+	2	) =	0.4
Arms	: 0.2 x	3	x (	4	+	4	+	3	) =	6.6
Trunks	: 0.3 x	1	x (	3	+	2	+	1	) =	1.8
Legs	: 0.4 x	0	x (	2	+	2	+	1	) =	0
TOTAL SCORE										8.8

Figure 3.2.3.12-2 Specific Details – Area Body Chart

2. Dermatology Life Quality Index (DLQI)

Dermatology Life Quality Index (DLQI)

Dermatology Life Quality Index DLQI [Calculate Score](#)

Figure 3.2.3.12-3 Specific Details –DLQI

STEP 3

Click on the 'Calculate Score' hyperlink shall display assessment screen as below:

DERMATOLOGY LIFE QUALITY INDEX (DLQI)

Please tick one box for each question

Over the last week	Very much	A lot	A little	Not at all	Not relevant
1 How itchy, sore, painful or stinging has your skin been ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 How embarrassed or self conscious have you been because of your skin ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 How much has your skin interfered with you going shopping or looking after your home or garden ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 How much has your skin influenced the clothes you wear ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 How much has your skin affected any social or leisure activities ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 How much has your skin made it difficult for you to do any sport ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Has your skin prevented you from working or studying ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Relevant If No, over the last week how much has your skin been a problem at work or studying ?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8 How much your skin created problems with your partner or any of your close friends or relatives ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 How much has your skin caused by any sexual difficulties ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 How much of a problem has the treatment for your skin been, for example by making your home messy, or by taking up time ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DLQI =

Figure 3.2.3.12-4 Specific Details –DLQI Questionnaire

STEP 4

Tick on the answers check box for each question


Details of the score description as below:

No.	Name	Description
1.	How itchy, sore, painful or stinging has your skin been? <i>Setakat manakah kulit anda berasa gatal atau sakit?</i>	User shall need to tick one of below answer: a) Very Much: 3 b) A lot: 2 c) A little: 1 d) Not at all: 0
2.	How embarrassed or self conscious have you been because of your skin? <i>Setakat manakah anda berasa malu atau segan, disebabkan oleh kulit anda?</i>	User shall need to tick one of below answer: a) Very Much: 3 b) A lot: 2 c) A little: 1 d) Not at all: 0
3.	How much has your skin interfered with you going shopping or looking after your home or garden? <i>Setakat manakah kulit anda mengganggu anda daripada pergi membeli-belah atau menjaga rumah atau berkebun?</i>	User shall need to tick one of below answer: a) Very Much: 3 b) A lot: 2 c) A little: 1 d) Not at all: 0 e) Not relevant: 0
4.	How much has your skin influenced the clothes you wear? <i>Setakat manakah kulit anda mempengaruhi pakaian yang anda pakai?</i>	User shall need to tick one of below answer: a) Very Much: 3 b) A lot: 2 c) A little: 1 d) Not at all: 0 e) Not relevant: 0
5.	How much has your skin affected any social or leisure activities? <i>Setakat manakah kulit anda mengganggu aktiviti-aktiviti sosial atau masa lapang anda?</i>	User shall need to tick one of below answer: a) Very Much: 3 b) A lot: 2 c) A little: 1

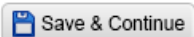
			d) Not at all: 0 e) Not relevant: 0
6.	How much has your skin made it difficult for you to do any sport? <i>Setakat manakah keadaan kulit anda menyebabkan anda tidak selesa semasa bersukan?</i>		User shall need to tick one of below answer: a) Very Much: 3 b) A lot: 2 c) A little: 1 d) Not at all: 0 e) Not relevant: 0
7.	Has your skin prevented you from working or studying? <i>Adakah kulit menyebabkan anda tidak dapat kerja atau belajar?</i> Yes/ya <input type="checkbox"/> No/Tidak <input type="checkbox"/> Not relevant/tidak <input type="checkbox"/> berkenaan <ul style="list-style-type: none"> If "No", over the last week how much has your skin been a problem at work or studying? Jika 'Tidak', setakat manakah kulit anda menjadi masalah semasa kerja atau belajar? 		User shall need to tick one of below answer: a) Yes: 3 b) No: If 'No' then allow user to choose: <ul style="list-style-type: none"> A lot: 2 A little: 1 Not at all: 0 c) Not relevant: 0
8.	How much has your skin created problems with your partner or any of your close friends or relatives? <i>Setakat manakah kulit anda menimbulkan masalah dengan teman, rakan baik atau saudara-mara anda?</i>		User shall need to tick one of below answer: a) Very Much: 3 b) A lot: 2 c) A little: 1 d) Not at all: 0 e) Not relevant: 0
9.	How much has your skin caused any sexual difficulties? <i>Setakat manakah kulit anda menyebabkan sebarang masalah hubungan seks?</i>		User shall need to tick one of below answer: a) Very Much: 3 b) A lot: 2 c) A little: 1 d) Not at all: 0 e) Not relevant: 0
10.	How much of a problem has the treatment for your skin been, for example by making your home messy, or by taking up time? <i>Setakat manakah rawatan kulit anda menimbulkan masalah seperti mengotori rumah anda atau mengambil masa anda?</i>		User shall need to tick one of below answer: a) Very Much: 3 b) A lot: 2 c) A little: 1 d) Not at all: 0 e) Not relevant: 0
11.	DLQI		Auto calculate as below: Total of the Score Question 1 to 10

Table 3.2.3.12-2 Specific Details – Psoriasis

STEP 5

Click on the  button to save the DLQI record

STEP 6

Click on the  button to save and continue with reporting section

STEP 7

Click on the  button to confirm save record

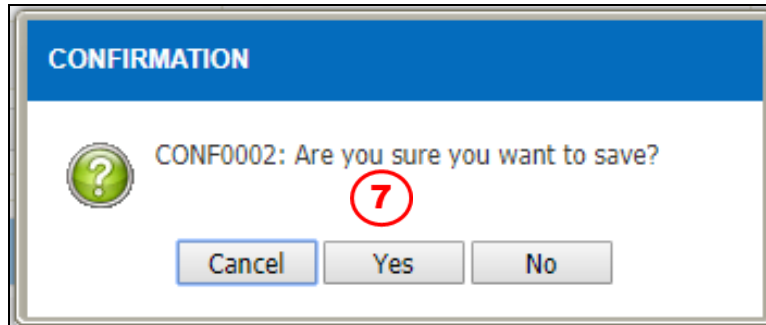


Figure 3.2.3.12-5 Confirmation Alert Message

STEP 8

Click on the  button to confirm record

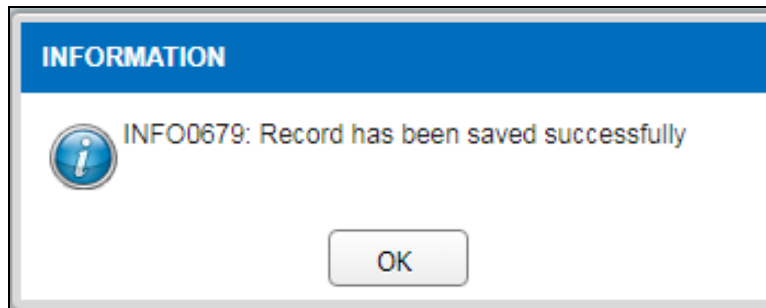


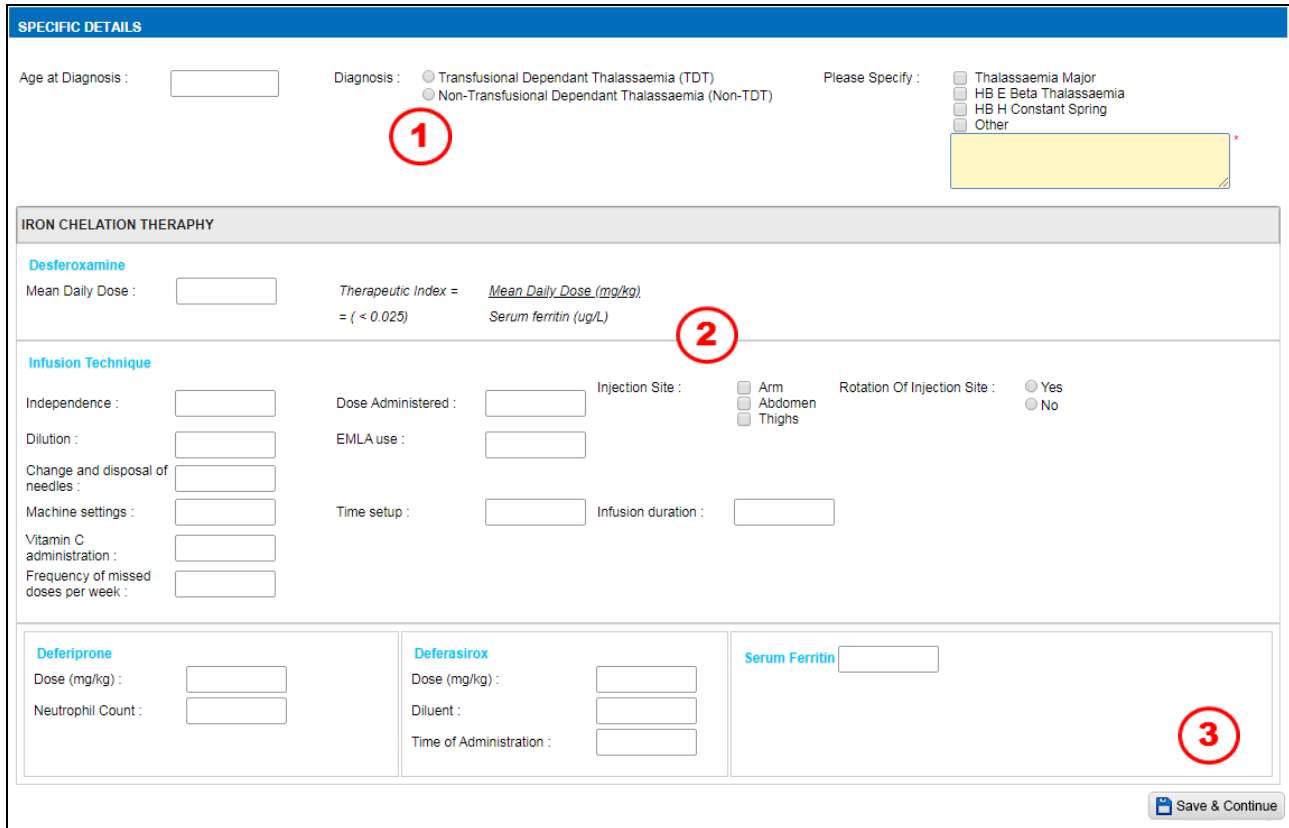
Figure 3.2.3.12-6 Information Alert Message

Note

- For 'Reporting' section, repeat **Note (Page 28) to Step 32** as in 3.2.1 Create New MTAC Reporting with No Specific Details.
- If patient has previous history, Psoriasis record will appear in MTAC History

3.2.3.13 Thalassaemia

This function allow user to record Specific Details for Thalassaemia for MTAC patients.



SPECIFIC DETAILS

Age at Diagnosis :

Diagnosis : Transfusional Dependant Thalassaemia (TDT) Non-Transfusional Dependant Thalassaemia (Non-TDT)

Please Specify : Thalassaemia Major HB E Beta Thalassaemia HB H Constant Spring Other

IRON CHELATION THERAPY

Desferoxamine

Mean Daily Dose : Therapeutic Index = $\frac{\text{Mean Daily Dose (mg/kg)}}{\text{Serum ferritin (ug/L)}}$ = (< 0.025)

Infusion Technique

Independence : Dose Administered : Injection Site : Arm Abdomen Thighs

Dilution : EMLA use : Rotation Of Injection Site : Yes No

Change and disposal of needles : Machine settings : Time setup : Infusion duration :

Vitamin C administration : Frequency of missed doses per week :

Deferiprone

Dose (mg/kg) : Neutrophil Count :

Deferasirox

Dose (mg/kg) : Diluent : Time of Administration :

Serum Ferritin

Figure 3.2.3.13-1 Specific Details – Thalassaemia

Note

Repeat **STEP 1 to 16** as in 3.2.1 Create New MTAC Reporting with No Specific Details before performing MTAC Reporting - Specific Details for Thalassaemia

STEP 1

Fill up the specific details for Thalassaemia by the below categories:

- Age at Dignosis
- Dignosis
- Please specify type of Thalassaemia

STEP 2


Fill up the **Iron Chelation Therapy** details as below :

- Desferoxamine
- Infusion Technique
- Deferiprone

-Deferasirox

-Serum Ferritin

STEP 3

Click on the  button to save and continue with reporting section

STEP 4

Click on the  button to confirm save record

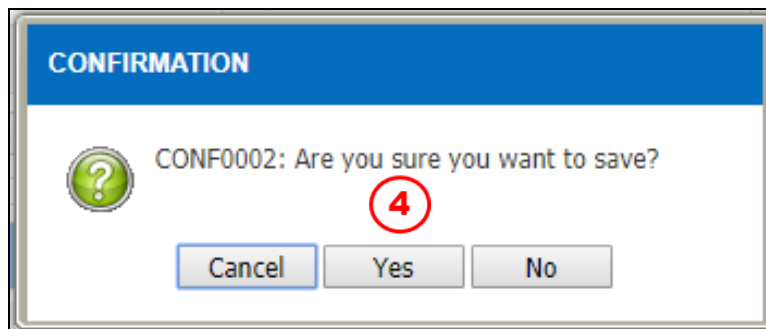


Figure 3.2.3.13-2 Confirmation Alert Message

STEP 5

Click on the  button to confirm record

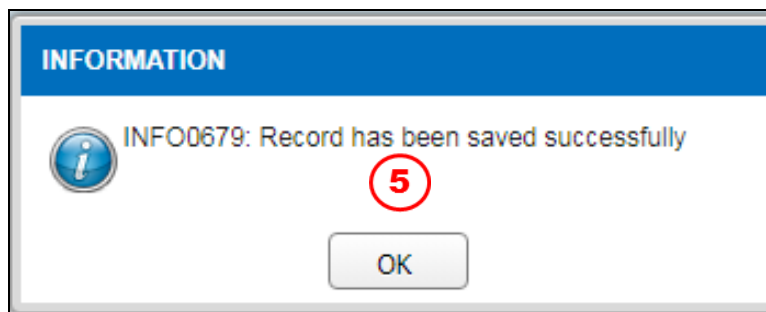


Figure 3.2.3.13-3 Information Alert Message

Note

- For 'Reporting' section, repeat **Note (Page 28) to Step 32** as in 3.2.1 Create New MTAC Reporting with No Specific Details.
- If patient has previous history, Haemophilia record will appear in MTAC History

4.0 Acronyms

Abbreviation	Definition
PhIS	Pharmacy Information System
MOH	Ministry of Health
CPS	Clinical Pharmacy System
PM	Patient Management
eGL	Electronic Guarantee Letter
HRMIS	Human Resource Management System
MRN	Medical Record Number
MTAC	Medication Therapy Adherence Clinic

5.0 Links to Clinical Modules

No	Module	PDF Links	No	Module	PDF Links
1	<i>Inpatient</i>	Click Here	12	<i>CDR Dispensing</i>	Click Here
2	<i>CDR Order</i>	Click Here	13	<i>Methadone Dispensing</i>	Click Here
3	<i>TDM Order</i>	Click Here	14	<i>PN Dispensing</i>	Click Here
4	<i>PN Order</i>	Click Here	15	<i>Order Management</i>	Click Here
5	<i>IV Order</i>	Click Here	16	<i>Patient Management</i>	Click Here
6	<i>Prepacking</i>	Click Here	17	<i>Radiopharmaceutical</i>	Click Here
7	<i>Galenical</i>	Click Here	18	<i>Outpatient</i>	Click Here
8	<i>MTAC</i>	Click Here	19	<i>Special Drug Request</i>	Click Here
9	<i>ADR & DAC</i>	Click Here	20	<i>MAR</i>	Click Here
10	<i>Medication Counselling</i>	Click Here	21	<i>DICE</i>	Click Here
11	<i>Ward Pharmacy</i>	Click Here	22		