

DIALYSIS APPLICATION FORM 洗肾申请表

Dialysis Subsidy: Vascular Access Subsidy:

Ref No.

Issued On

Rec'd On

A. PERSONAL PARTICULARS 个人资料

Name 姓名 (中/英):

I/C NO 身份证号码: AGE 年龄:

DATE OF BIRTH 出生日期: DAY 日: MONTH 月: YEAR 年:

NATIONALITY 国籍: MALAYSIAN 马来西亚公民: OTHERS 其他:

RACE 种族: CHINESE 中: MALAY 巫: INDIAN 印: OTHERS 其他:

SEX 性别: MALE 男: FEMALE 女: RELIGION 信仰:

LANGUAGE 语言: MALAY 马来语: MARITAL STATUS 婚姻状况: SINGLE 单身:
ENGLISH 英语: MARRIED 已婚:
CHINESE 华语: DIVORCED 离婚:
TAMIL 淡米尔语: WIDOW 寡妇:
OTHERS 其他: WIDOWER 鳏夫:

PERMANENT ADDRESS 永久地址:

TEL 电话: H/P 手提电话:

CORRESPONDENCE ADDRESS 通讯地址:

TEL 电话: H/P 手提电话:

TYPE OF ACCOMMODATION 住所种类

OWN 自己: Fully Paid 付清: On Installment 供期: RM /mth
RENT 租 [RM /month]:
LOW COST 廉价组屋: APARTMENT/CONDO 公寓: SINGLE STOREY 单层排屋:
DOUBLE STOREY 双层排屋: SHOPHOUSE 店屋: OTHERS 其他:

B. EDUCATION BACKGROUND 学历

Primary 小学	Year 年份	Name of School 学校名称	Results 成绩
Secondary 中学			
STPM 高级教育文凭			
University/College 大学/学院			
Others 其他			

C. DETAILS OF EMPLOYMENT 工作资料

OCCUPATION 职业: _____ MONTHLY INCOME 每月收入: _____

EMPLOYER 雇主: _____ TEL 电话: 0 1 _____

EMPLOYER ADDRESS 雇主地址: _____

IF UNEMPLOYED, PLEASE STATE 若失业, 请说出:

Since 何时: _____

Reason 原因: _____

EPF 公积金: YES 有: NO 没有: EPF NO 公积金号码: _____

SOCSSO 社险: YES 有: NO 没有: SOCSSO NO 社险号码: _____

INSURANCE 保险: YES 有: NO 没有: INSURANCE NO 保单号码: _____

INCOME TAX 所得税: YES 有: NO 没有: INCOME TAX NO 所得税号码: _____

DRIVING LICENCE 驾驶执照: YES 有: NO 没有:

D. FINANCIAL BACKGROUND 经济情况

a) SUPPORTED BY FAMILY 何时: YES 有: NO 没有:

Contribution per month 每月数额: RM _____

b) CONTRIBUTION BY RELATIVE/FRIEND/COMPANY 亲戚/朋友/公司资助: YES 有: NO 没有:

Name of company 公司名字: _____ Company tel.no 公司电话号码: 0 _____

Contribution per month 每月数额: _____

c) CONTRIBUTION BY CHARITABLE ORGANISATION 慈善机构资助: YES 有: NO 没有:

Contribution per month 每月数额: _____

E. APPLICANT FAMILY INFORMATION 申请人家庭资料

1. List of family members staying together 同住家庭成员

No	Name 名字	Relationship 关系	Age 年龄	Occupation 职业	Marital Status 婚姻近况	No of Children 孩子数目	Monthly income 月入

2. List of family members not staying together 不同住家庭成员

No	Name 名字	Relationship 关系	Age 年龄	Occupation 职业	Marital Status 婚姻近况	No of Children 孩子数目	Monthly income 月入	Contribution to applicant 贡献

F. TOTAL MONTHLY HOUSEHOLD INCOME AND EXPENDITURE 家庭成员每月收入及支出报告

1. INCOME 收入

RM

Own Income (applicant)		个人收入	_____
Household Family Income (E1)	姓名 (中/英):	家里成员收入	_____
Contribution from children (E2)		其他孩子贡献	_____
Other Income :	_____	其他收入	_____
		TOTAL INCOME 总收入	_____

2. EXPENDITURE 支出

RM

EPF / SOCSO		公积金	_____
Food		伙食	_____
House Installment		住宅供期	_____
House Rental		租金	_____
Vehicle Installment		交通工具供期	_____
Schooling Expenses		教育费用	_____
Utilities (Water, Electricity, Telephone, Astro & etc)		杂费	_____
Transportation		交通费用	_____
Other expenses :		其他	_____
		TOTAL EXPENDITURE 总开支	_____

3. BALANCE INCOME 收入余额

RM

TOTAL INCOME 总收入	_____	
TOTAL EXPENDITURE 总开支	_____	
		BALANCE 余额

4. MEDICAL EXPENSES 医疗费用

RM

Dialysis Fee 洗肾费用	_____
Medication 医药	_____
Injection EPO 补针费用	_____
Others 其他	_____

DECLARATION

We, _____ (Name of witness) and _____
(Name of the patient) hereby confirm that:

- i. We have read, understood and agreed to comply with the terms and conditions. Contained herein, all the particulars given in this form are true and we have not suppressed any information required.
- ii. If the patient/witness have suppressed or given any incorrect information, MMF reserves the right to terminate the dialysis treatment and we will not take any legal action against MMF.
- iii. We also understand that if this application is successful, the patient will be accepted for dialysis for only 6 months and MMF will only serve as a temporary bridging financial assistance while patients apply for long-term financial support/government subsidies.
- iv. Upon acceptance, we agree to obey all the rules and regulations set by MMF Committee.
- v. I hereby consent to my personal data being collected, used and processed by PMSB for purposes of payment of haemodialysis treatment and any haemodialysis related/supporting treatment and other purposes ancillary or related thereto, and I further authorise my personal data to be disclosed for the purposes above to third party service providers, product suppliers or private healthcare centres.

宣言

我们, _____ (见证人姓名) 和 _____
(病人姓名) 谨此确认:

1. 我们已阅读, 理解并同意遵守本条款及条件。所有在本表格内的资料均属真实, 我们没有抑制所需的任何信息。
2. 如果病人/证人都有抑制或给予任何不正确的信息, MMF保留终止透析治疗的权利, 和我们不会对MMF采取任何法律行动。
3. 我们也明白, 如果这个申请是成功的, 患者将接受透析治疗只限6个月和MMF只作为给患者在等待政府血液透析治疗补助金申请的批准期间的一个短暂的经济协助。
4. 一旦接受, 我们同意遵守所有MMF委员会制定的规则和规定。
5. 我同意我的个人资料由马自达医疗保险基金收集, 使用和处理, 用于支付血液透析治疗和任何血液透析相关/支持性治疗和其他辅助或相关的目的, 我允许进一步授权将我的个人资料透露给第三方服务提供商, 产品供应商或私人医疗中心。

Signature of patient 申请者签名

Name 姓名: _____

I/C No. 身份证号码: _____

Date 日期: _____

Signature of witness 见证人签名

Name 姓名: _____

I/C No. 身份证号码: _____

Relationship 关系: _____

Occupation 职业: _____

Address 地址: _____

Tel no. 电话: _____

Date 日期: _____

MEDICAL REPORT

Part 1: Personal Information

Full Name (Mr. / Mrs. / Ms. / Mdm):

Address:

_____ Postcode: _____

Home Tel No: 0 _____ H/P no: 0 1 _____

Date of birth: _____ Age: _____ Gender: Male Female

Nationality: _____ NRIC: _____

Race: _____ Marital Status: Single Married Separated Divorced Widowed

Part 2: Details of Next of Kin

Full Name (Mr. / Mrs. / Ms. / Mdm):

Relationship:

Address:

_____ Postcode: _____

Home Tel No: 0 _____ H/P no: 0 1 _____

Patient Signature

Name: _____

Date: _____

Part 3: This report must be filled in by referring nephrologist / physician

1. Type of vascular access

Type	Date	Location	Functional status
None			
Centre Venous Catheter			
AV Fistula			
AV Graft			

2. Present mode of treatment

Conservative / IPD CCPD CAPD Haemodialysis

Date of first dialysis: Place of dialysis:

3. Current Medication

4. Other medical information which maybe of relevance to patient's treatment

5. Latest blood investigation results (fill in and attach printed copy of results)

	Results	Date
Haemoglobin (g/dl)		
Urea (mmol)		
Creatinine (umol)		
Calcium (umol)		
Phosphate (mmol)		
ALT (IU/L)		
HBsAg (IU/L)		
HBsAB (IU/L)		
HCV (IU/L)		
HV (IU/L)		

Part 4: Questionnaire (Please complete in full)

No	Results	Yes	No	Specify
1	Is the patient mentally or physically impaired?			
2	Is patient ambulant?			
3	Is patient fit for satellite haemodialysis?			
4	Is patient allergic to any medication?			
5	Does the patient have any significant co-morbidities disease (s) that would mitigate against response to treatment? If yes, please specify: - coronary artery disease - cerebrovascular disease - peripheral vascular disease - chronic pulmonary disease - chronic hepatitis disease - diabetes mellitus			
6	Has the patient had any previous surgery?			
7	Has the patient undergone any complication during dialysis? If yes, please specify.			
8	Has the patient been vaccinated against Hepatitis B? If yes, please indicate date given and total of doses given so far.			
9	Is patient likely to be medically fit to work?			

Signature of Physician / Nephrologist

Name: _____

Date: _____

Hospital stamp:

Part 5:

1. Assessment from Staff Nurse

Name: _____

Date: _____

No	Check List	Yes	No	Specify
1	Would patient like to apply the subsidy from Mazda Medicare Fund? If No, please specify.			
2	Has patient prepare all the investigation documents as below: - Medical report - Latest laboratory result (within 6 months) - Latest ECG result (within 6 months) - Latest chest X-ray result (within 6 months)			
3	Does patient has any vascular access? If yes, please specify where, when and how is the type of access? - Centre Venous Catheter - Native Fistula - Others			
4	Has patient medication reviewed? (please remind to bring all when visit to doctor)			

2. Summary of Medical Report from Nephrologist / Physician

Comment from nephrologist / physician : Approved / Not Approved

Signature of Physician / Nephrologist

Name (with chop):

Date: _____

SUPPORTING DOCUMENT CHECKLIST 所需文件清单

Documents from applicant 申请者文件

- | | |
|---|-------|
| 1) 二张身份证副本及四张护照型照片
2 photocopy of I/C & 4pcs Latest Passport Size Photo | _____ |
| 2) 医药报告及心脏电跳图(若有)
Medical Report from hospital & ECG report (if any) | _____ |
| 3) 最新 3 个月內之验血报告 -
必需包括梅毒检验, 愛滋病 I & II 形抗體, A、B、C 肝炎抗体及抗原
Blood test report with VDRL (RPR), HIV I & II, Hepatitis A, B, C,
Antigen and Antibody (must within 3 months) | _____ |

Documents from and applicant and family members 申请者及家庭成员文件

- | | |
|--|-------|
| 1) 薪水单或雇主证明薪水信
Latest Salary Slip or Certify letter from Employer | _____ |
| 2) 所得稅单据
Latest B/BE Form & EA Form | _____ |
| 3) 公积金单据, 或曾经提款之收据
Latest EPF Statement or Proof of EPF withdrawal statement (if any) | _____ |
| 4) 存款帐簿副本、往來帳戶陳述、定期存款表
Photocopy of saving account passbook, current account bank statements or FD slip | _____ |
| 5) 租屋或分期付款收据
Photocopy of Housing loan document / Housing rental receipt | _____ |
| 6) 汽車贷款信件
Photocopy of Hire Purchase Agreement schedule | _____ |
| 7) 保險保单信件
Photocopy of Insurance Policy Schedule | _____ |
| 8) 信用卡帳单
Latest Credit card statement | _____ |
| 9) 电、水、电话和 Astro 帳单副本
Photocopy of Utility bills (electricity, water, telephone, Astro & etc) | _____ |

LIST OF B. BRAUN DIALYSIS CENTRES IN MALAYSIA

No	Dialysis Center	Dialysis Information Center
1	B.Braun Avitum Dialysis Centres -Puchong	<p>No. 8-0, Jalan Puteri 4/2, Bandar Puteri, 47100 Puchong Selangor Darul Ehsan</p> <p>T: 03-80600863/0380666496 F: 03-80600851 E-mail: bars_puchong@apmail.bbraun.com</p>
2	B.Braun Avitum Dialysis Centres -Butterworth	<p>No 25, Tingkat Mawar, Taman Mawar, Jalan Raja Uda, 12300 Butterworth, Pulau Pinang</p> <p>T: 04-3323005/04-3133375 F: 04-3323006 E-mail: bars_butterworth@apmail.bbraun.com</p>
3	B.Braun Avitum Dialysis Centres -Kota Kinabalu	<p>Lot 6, Block C, Lintas Jaya, Uptownship, Jalan Lintas, Kepayan Highway, 88300, Kota Kinabalu, Sabah</p> <p>T: 088-724754 F: 088-724946 E-mail: bars_kotakinabalu@apmail.bbraun.com</p>
4	B.Braun Avitum Dialysis Centres -Tawau	<p>Lot A14& A15, Ground & First Floor, Hot Spring Commercial Complex, Jalan Air Panas, 91000 Tawau, Sabah</p> <p>T: 089-714119 F: 089-714110 E-mail: bars_tawau@apmail.bbraun.com</p>
5	Pusat Haemodialisis Harmoni - Cheras	<p>15, Jalan 4/101C, Cheras Business Centre, Jalan Cheras Batu 5, 56100 Kuala Lumpur</p> <p>T: 03-91328051/03-91338957 F: 03-91308051 E-mail: harmoni_cheras@apmail.bbraun.com</p>
6	Pusat Haemodialisis Harmoni - Shamelin	<p>79, Jalan10/91, Taman Shamelin Perkasa 56100 Kuala Lumpur</p> <p>T: 03-92848052/03-92002171 F: 03-92848052 E-mail: harmoni_shamelin@apmail.bbraun.com</p>

LIST OF B. BRAUN DIALYSIS CENTRES IN MALAYSIA (count'd)

7	Pusat Haemodialisis Harmoni - Sungai Long (Kajang)	2, Ground Floor, Jalan SL 1/12, Bandar Sungai Long, 43000 Kajang Selangor T: 03-90198052/03-90100478 F: 03-90198052 E-mail: harmoni_sglong@apmail.bbraun.com
8	Pusat Haemodialisis Harmoni - Kota Damansara	G-65-G, Jalan Teknologi 3/9, Bistari De Kota, PJU 5 Kota Damansara, 47810 Petaling Jaya, Selangor T: 03-61421052 F: 03-61421052 E-mail: harmoni_kotadsara@apmail.bbraun.com
9	Smart Care - Klinik Pakar Dialisis - Cheras	46, Jalan Cerdas, Taman Connaught, 56100 Cheras, Kuala Lumpur T: 03-91003657 F: 03-91003658 E-mail: sc_cheras@apmail.bbraun.com
10	Smart Care - Klinik Pakar Dialisis - UEP Subang Jaya	52G Jalan USJ 10/1B, UEP Subang Jaya, 47620 Petaling Jaya, Selangor Darul Ehsan T: 03-56337618 F: 03-56330618 E-mail: sc_usj@apmail.bbraun.com
11	Pusat Dialisis CAT Negeri Pulau Pinang - Daerah Barat Daya	Ground Floor, Kompleks Pasar Awam MPPP, Balik Pulau, Daerah Barat Daya, 11000 Pulau Pinang T: 04-8662545 F: 04-8661903 E-mail: catdc_balikpulau@apmail.bbraun.com
12	Renal Link Dialysis Centre	408-G-1, Jalan Perak, 11600 Pulau Pinang T: 04-2820292 F: 04-2820292 E-mail: renallink@gmail.com