PEMEGANG AMANAH YAYASAN KEBAJIKAN SSL HAEMODIALYSIS BERDAFTAR
修成林洗肾福利基金

DIALYSIS APPLICATION FORM 洗肾申请表格

Ref No.	
Issued On	
Rec'ed On	

A. PERSONAL PARTICULARS 个人资料

NAME 姓名（中/英） :

NRIC 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 华 ☐ MALAY 巫 ☐ INDIAN 印 ☐ OTHERS 其他_____

SEX 性别 : ☐ MALE 男 ☐ FEMALE 女 RELIGION 宗教 :

LANGUAGE 语言 : ☐ MALAY 马来语 ☐ ENGLISH 英语 ☐ CHINESE 华语
☐ TAMIL淡米尔语 ☐ OTHERS 其他_____

MARITAL STATUS 婚姻状况 : ☐ SINGLE 单身 ☐ MARRIED 已婚 ☐ DIVORCED 离婚
☐ WIDOW 寡妇 ☐ WIDOWER 鳏夫

NO. OF CHILDREN 儿女人数 : ☐

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 自置 : ☐ 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. EDUCATIONAL BACKGROUND 学历

Level / Course 学历/课程	Year 年份	Name of School 学校名称	Results 成绩
Primary 小学			
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 : -

EMPLOYER ADDRESS 雇主地址 :

IF UNEMPLOYED, PLEASE STATE LAST OCCUPATION :
若失业，请注明上一份职业 :

Since 何时 :

Reason 原因 :

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

SOCSO 社险 : ☐ YES 有 ☐ NO 没有 SOCSO NO号码 : _____

INSURANCE 保险: ☐ YES 有 ☐ NO 没有 POLICY NO号码 : _____

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

DRIVING LICENCE 驾驶执照: ☐ YES 有 ☐ NO 没有

D. FINANCIAL BACKGROUND 经济情况

a) SUPPORTED BY FAMILY 家庭成员支付 : ☐ 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 : -

Contribution per month 每月数额 : RM -

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

Contribution per month 每月数额 : RM -

E. APPLICANT FAMILY INFORMATION 申请者家庭资料

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 婚姻状况	No. Of Children 孩子数目	Monthly Income 月入	Contribution To Applicant 給予资助

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 婚姻状况	No. Of Children 孩子数目	Monthly Income 月入	Contribution To Applicant 給予资助

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)	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

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

NO.	DESCRIPTION	RM
1	TOTAL INCOME 总收入	
2	TOTAL EXPENDITURE 总开支	
	BALANCE 余额	

4. MEDICAL EXPENSES 医疗费用

NO.	DESCRIPTION	RM
1	Dialysis Fee 洗肾费用	
2	Medication 医药	
3	EPO Injection EPO（补针）费用	
4	Others 其他	

PEMEGANG AMANAH YAYASAN KEBAJIKAN SSL HAEMODIALYSIS BERDAFTAR

SELECTION CRITERIA FOR THE HAEMODIALYSIS PROGRAMME

修成林洗肾福利基金 - 血液透析治疗(洗肾)申请条件

1 Applicant is a Malaysian Citizen.
申请者必须是马来西亚公民。

2 Applicant is aged 18 years and above or as per MOH guidelines.
申请者必须18岁或以上，或根据马来西亚卫生部的指南。

3 Applicant must have a full dose of COVID-19 vaccination.
申请者必须完成新冠肺炎的疫苗接种。

4 Applicant is an ambulant OR ambulatory disabled.
申请者必须具备行动能力；残障人士亦然。

5 Applicant has suitable functional vascular access, except for a temporary Femoral Catheter.
申请者必须拥有运作良好的动静脉造瘘，临时股静脉导管除外。

6 Applicant must undergo routine blood test to monitor medical condition and assess health condition.
申请者必须定期进行血液检查，以监测病情及评估健康状况。

7 Applicant must be certified medically fit by SSL's panel Consultant Nephrologist.
申请者必须由修成林所指定的肾脏专科医生证明符合本中心的医药条件。

8 Applicant is prepared to meet the SSL Committee Member before being considered for the programme.
申请者同意在获准参与本疗程前，与修成林理事会成员会面。

9 Applicant must agree to a Committee and Social Worker's visit to his/her home with a view to verifying all information given.
申请者必须同意接受本中心理事会成员及社工进行家访，以核实所提供的资料。

10 Applicant agrees to pay RM60.00 for each dialysis session, plus RM18.00 for a single-use dialyzer, for the first 6 months of dialysis. Thereafter, standard treatment charges will apply and are subject to revision by SSL.
申请者同意在开始接受本中心洗肾治疗后的首6个月内，每次缴付RM60.00的洗肾治疗费及RM18.00的一次性透析器费用。6个月后，将按标准治疗收费，有关收费可由修成林调整。

11 Applicants who are not eligible for subsidies from the Kementerian Kesihatan Malaysia (KKM) or PERKESO shall pay the standard treatment fee, subject to revision by SSL.
凡不符合马来西亚卫生部（KKM）或社会保险机构（PERKESO）补贴资格的申请者，须缴付标准洗肾治疗费，有关收费可由修成林调整。

12 The selected patient must undergo dialysis three times a week, four hours per session, at the Centre's scheduled times, unless otherwise prescribed by a Nephrologist.
获批准的患者须按照本中心规定的时间接受洗肾治疗，即每周3次，每次4小时，除非肾脏专科医生另有医嘱。

13 Reselection-The patient is reviewed every 6 months with regards to his suitability to continue on the dialysis programme.
本中心将在每6个月对病人进行评估，以确定病人是否适合继续于本中心进行洗肾。

14 The patient's programme can be terminated if:
病人的洗肾疗程可被终止，若：

(a) He/She fails to turn up for more than 3 successive dialysis sessions without a valid reason.
病人连续3次无故缺席洗肾。

(b) He/She is bed-ridden
病人卧病在床。

(c) His/Her health condition has deteriorated or is unstable such as needing oxygen support etc.
病人健康状况衰退或不稳定，如:需要氧气支援等。

(d) He/She is uncooperative and fails to abide to the terms of the agreement.
病人不予配合，且不遵守协议条款。

15 The patient must sign an agreement with SSL before commencing the dialysis programme.
病人必须在开始接受洗肾治疗前，与修成林洗肾福利基金签署合约。

16 Applicants who are HIV-positive or have co-infection with Hepatitis B and Hepatitis C will not be accepted by SSL.
本中心恕不接受HIV阳性者。此外，申请者若有B型肝炎与C型肝炎双重感染，亦不予接受。

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. 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, SSL reserves the right to terminate the dialysis treatment and we will not take any legal action against SSL.

iii. We also understand that if this application is successful, the patient will be accepted for dialysis for only 6 months. Thereafter, the application will be reconsidered.

iv. Upon acceptance, we agree to obey all the rules and regulations set by Pemegang Amanah Yayasan Kebajikan SSL Haemodialysis Berdaftar "SSL".

宣誓

我们, _____(见证人姓名)与_____（申请者姓名）宣誓:

i. 我们已经阅读，明白及同意遵守所有的条规。所提呈的资料全属正确，以及没有任何隐瞒。

ii. 如本人或见证人有隐瞒或虚报资料，洗肾中心有权终止有关洗肾服务，病者/见证人不能对本中心采取任何法律行动。

iii. 我们也明白，若申请获得批准，患者接受洗肾治疗的期限为6个月（试用期），期满后将重新评估申请。

iv. 申请获得批准后，我们同意遵守修成林洗肾福利基金（SSL）所制定的一切规章制度。

_____
Signature of patient 申请者签名

Name 姓名 : _____

NRIC No. 身份证号码 : _____

Date 日期 : _____

_____
Signature of witness 见证人签名

Name 姓名 : _____

NRIC No. 身份证号码 : _____

Relationship关系 : _____

Occupation职业 : _____

Address 地址 : _____

_____

_____

Tel no. 电话 : _____

Date 日期 : _____

FOR OFFICE USE ONLY

Patient's Name : _____ NRIC No. : _____

MEDICAL ASSESSMENT

Doctor's Comments :	Date : ☐ Fit to transfer ☐ Not fit to transfer ☐ Others,please specify : Doctor's Signature : Doctor's Name (in block letter)
President / Vice President ☐ Approved ☐ Rejected, Reason : _____ ☐ Deferred, Reason : _____	Date : Signature :
Commencement of Dialysis Date of Commencement : _____ Date of Notification : _____	Date : Signature :

SUPPORTING DOCUMENTS 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 photocopies of I/C & 4pcs latest passport size photo

2) 医药报告及心电图（若有）
Medical report from hospital & ECG report (if any)

3) 血液检验报告（包括梅毒筛查（VDRL / RPR）、HIV I & II抗体、A型、B型及C型肝炎抗原与抗体检测；报告须为近3个月内的检验结果）
Blood test report with VDRL (RPR), HIV I & II, Hepatitis A, B, C,Antigen and Antibody
(must within 3 months)

Documents from 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 payslip or certify letter from employer

2) 所得税单据
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、往來帐戶陳述、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) 保险保单信件
Photocopy of insurance policy schedule

8) 信用卡帐单
Latest credit card statement

9) 电、水、电话和Astro帐单副本
Photocopy of utility bills (electricity, water, telephone, Astro & etc)

10) 住家照片 （大门，客厅，厨房及卧室）
Photos of residence (front, living hall, kitchen & bedroom)

備註 Notes:

1) 如申请文件不完整，或所提供的资料存在虚假、误导性陈述，或隐瞒影响补助资格的重要信息，修成林有权拒绝该申请；如已开始提供洗肾服务，修成林亦有权在发出通知后暂停或终止有关服务。
If the application is incomplete or contains false, misleading, or undisclosed information that affects subsidy eligibility, SSL reserves the right to reject the application or, upon notice, suspend or terminate dialysis services.

2) 申请表格及所有所需文件必须于领取表格之日起两周内提交至本中心。因任何原因导致的逾期提交，本中心概不负责。
The application form with all supporting documents, must be submitted to SSL within two (2) weeks from the date of collection. SSL shall not be responsible for delay in submission arising from any cause.

MEDICAL REPORT

To the Doctor incharge,

- *Kindly complete the questionnaire in full. The report should indicate the period for which the patient was put under care of the referring physician and provide an adequate resume of the patient's clinical history.*
- *If the referring physician has specific reservations about the medical suitability of the patient for the treatment applied for, these should be clearly declared.*
- *The referring Nephrologist should undertake to continue to treat the patient jointly with Pemegang Amanah Yayasan Kebajikan SSL Haemodialysis Berdaftar after the patient is accepted for dialysis.*

Patient's Name : _____ Physician's Name : _____

Patient I/C No. : _____ Physician's Clinic/Hospital : _____

Diagnosis Primary _____

Secondary _____

1. SUMMARY OF MEDICAL REPORT :

_____

_____

_____

_____

_____

2. SPECIFIC QUESTIONS

(SPECIFY)

a) Is the patient mentally or educationally normal ? ◯ Yes ◯ No _____

b) Is the patient ambulant ? ◯ Yes ◯ No _____

c) Does the patient suffer any vision,hearing or physical disability? ◯ Yes ◯ No _____

d) Has the patient had any previous surgery (including transplantation)? ◯ Yes ◯ No _____

e) Does the patient have other significant disease(s) that would mitigate against response to treatment ? ◯ Yes ◯ No _____

If so, please specify :

- Coronary artery disease ☐ Yes ☐ No
- Cerebrovascular disease ☐ Yes ☐ No
- Peripheral vascular disease ☐ Yes ☐ No
- Chronic pulmonary disease ☐ Yes ☐ No
- Diabetes mellitus ☐ Yes ☐ No
- Malignancy ☐ Yes ☐ No
- Other systemic disease ☐ Yes ☐ No _____

f) Has the patient undergone peritoneal dialysis? ◯ Yes ◯ No

If yes, please specify : ☐ *Acute* ☐ *Long Term*

g) Has the patient been considered for transplantation ? ◯ Yes ◯ No

If yes, please specify : ☐ *Living related* ☐ *Cadaveric*

h) Is the patient likely to be medically fit to work ? ◯ Yes ◯ No _____

i) Allergy : ◯ Yes ◯ No _____

j) Other medical illness : _____

_____

3. VASCULAR ACCESS

☐ AV Fistula ☐ AV Graft ☐ Others,_____

Date Created : _____Location : _____ In Use : Yes ◯ No ◯

4. CURRENT TREATMENT :

☐ Conservative ☐ IPD ☐ CAPD ☐ Heamodialysis

Date of first dialysis : _____ Place of dialysis : _____

5. INVESTIGATIONS (*Please attach a copy of latest blood test result)*

HbsA	:	☐ positive	☐ negative	☐ not done
Anti HBS	:	☐ positive	☐ negative	☐ not done
Anti HCV	:	☐ positive	☐ negative	☐ not done
HIV	:	☐ positive	☐ negative	☐ not done
VDRL	:	☐ positive	☐ negative	☐ not done
MRSA Screen	:	☐ positive	☐ negative	☐ not done

Creatinine (umol/l) :_____ Urea (mmol/l) :_____

Potassium (mmol/l) : _____ HCO_3 (mmol/l) : _____

Calcium (mmol/l) : _____ Phosphate (mmol/l) : _____

ALT (iu/l) : _____ AST (iu/l) : _____

Albumin (g/l) : _____ HB (g/dl) : _____

6. CURRENT MEDICATIONS :

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

7. OTHER COMMENTS :

_____

_____

_____

_____ _____

Signature of Nephrologist / Physician Date

Hospital Chop :