PEMEGANG AMANAH YAYASAN KEBAJIKAN
SSL HAEMODIALYSIS BERDAFTAR
修成林洗腎福利基金
(Ruj: LHDN.01/35/42.51/179-6.4819)
(P. Jaya) No: 9, Jalan 5 Seksyen 1, 46000 Petaling Jaya, Selangor Darul Ehsan. Tel: (603) 7782 2293
(Puchong) Lot PT-39480, Jalan Industri PBP 3, Taman Industri, Pusat Bandar Puchong, 47100 Puchong, Selangor Darul Ehsan. Tel: (603) 5882 9006 Fax: (603) 5882 6255
(Donation) Mailing Address: No: 7, Jalan 5 Seksyen 1, 46000 Petaling Jaya, Selangor Darul Ehsan.
(Donation) Tel: (603) 7782 4092, 7782 7546 Fax: (603) 7783 7842
Website: www.sausenglum.com.my Email: management@sausenglum.org
Certificate No : GB03/58815
Certificate No : SG03/00018

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） :

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 华 ☐ MALAY 巫 ☐ INDIAN 印 ☐ OTHERS 其他_____

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

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

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. 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 : 若失业，请说出 :

Since 何时 :

Reason 原因 :

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

SOSCO 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	Maritul Status 婚姻近况	No. Of Children 孩子数目	Monthly Income 月入	Contribution To Applicant 貢獻

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	Maritul Status 婚姻近况	No. Of Children 孩子数目	Monthly Income 月入	Contribution To Applicant 貢獻

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	Injection EPO 补针费用	
4	Others 其他	

PEMEGANG AMANAH YAYASAN KEBAJIKAN SSL HAEMODIALYSIS BERDAFTAR
CONDITIONS FOR SELECTION INTO STAFF NURSE ASSISTANCE HAEMODIALYSIS PROGRAMME
修成林洗肾福利基金-申请进入护士协助洗肾中心之条件

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

2 Applicant is aged 16 years and above.
申请者必须16岁或以上。

3 Applicant is ambulant (able to move independently).
申请者必须行动方便

4 Applicant has a suitable functional vascular access.
申请者必须有良好运作的动静脉造瘘。

5 Applicant is prepared to have regular blood test to assess the medical condition and quality condition.
申请者必须接受例常验血，以作医药评估。

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

7 Applicant has no other recourse to regular Haemodialysis from charitable organisation.
申请者不能在其他慈善洗肾中心进行洗肾 。

8 Applicant is prepared to meet the SSL Committee Member before being considered for the programme.
申请者必须出席本中心理事会所预定的面试。

9 Applicant must agreed to a Committee and Social Worker's visit to his/her home with a view to verify all information given.
申请者必须接受本中心所委派的社工进行家访，以确定所提呈的资料是否正确。

10 Applicant is prepared to pay medical treatment fee of RM60.00 for each dialysis(after Government subsidy granted). This fee is subject to change by SSL.
申请者必须缴付每次RM60的洗肾费(获政府津贴批准).本中心有权随时更改其收费。

11 Applicant is prepared to pay a DIALYSIS DEPOSIT of RM300.00 before starting the dialysis with SSL.
It will be forfeited if the patient fails to turn up for dialysis during that week.
申请者未正式接受洗肾之前，必须预付RM300的洗肾押金。若申请者首星期没前来洗肾，其洗肾押金将被没收。

12 The selected patient must be willing to undergo dialysis at the Centre at the dates and times fixed by the Centre, three times per week, 4 hours per session.
病人必须遵守中心所规定的日期与时间进行洗肾，每周三次，每次四小时。

13 Reselection-The patient is reviewed every 6 months with regards to his suitability to continue on the dialysis programme.
本中心将在每六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 :
本中心基于以下条规，随时可以终止病人于本中心进行洗肾：

(a) He/She fails to turn up for more than 3 successive dialysis session without valid reasons.
病人若连续三次无故缺席洗肾。

(b) He/She is no longer ambulant.
病人行动不方便。

(c) His/Her condition has deteriorated with complications such as heart disease, infection, stroke etc.
病人不再符合本中心的医药条件，如：患有心脏病、传染病、中风等。

(d) He/She is uncooperative and fails to keep within the terms of the contract drawn up.
病人不合作及抵触合约的条规。

15 The patient must be willing to sign a contract with SSL before commencing the dialysis programme.
病人正式接受洗肾之前，必须与修成林洗肾福利基金签署合约。

16 Applicant with HIV positive and combined Hep B & Hep C infected patients will not be accepted by SSL.
本中心不接受爱滋病及B型+C型肝炎带菌者。

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. 同时，我们也明白，申请者必须经过6个月洗肾试用期，之后其申请将重新被考虑，以作出决定。

iv. 一旦申请被修成林洗肾中心接受，我们同意遵守中心内所有的规则。

_____
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 : _____

FOR OFFICE USE ONLY

Patient's Name : _____ I/C 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 文件核對

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 -
必需包括梅素检验，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 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)

備註 Notes:

1) 若以上之任何文件不完整， 本中心有权不接受或处理此申请。
* SSL reserve the right NOT TO ACCEPT the incomplete application form or without any supporting documents as listed above.
** Kami berhak MENOLAK borang permohonan yang tidak lengkap dan tidak melampirkan salinan dokumen yang mencukupi .

2) 所有以上所需要的文件必需在两个星期內呈交给修成林，任何延迟修成林将不负责。
* The application form and supporting documents MUST BE submitted to SSL within 2 weeks after collection of the form, SSL shall not be held responsible on any cause of delay
** Semua dokumen yang dikehendaki dalam senarai semakan MESTI diserahkan kepada SSL dalam masa dua minggu,sebarang kelewatan pihak SSL tidak akan bertanggungjawab.

3) 修成林将征收二十令吉报名费
* Registration fee of RM20.00 will be collected upon submission of application form .
** RM20.00 fi pendaftaran akan dikenakan.

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 ☐ Haemodialysis

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 :