

YAYASAN ST. JOHN AMBULANS MALAYSIA
Kawasan Pantai Selangor
(SJAM - KPS Foundation)
SJAM - KPS Haemodialysis
Bangunan Yeo Cheng Swee
2984A, Persiaran Raja Muda Musa,
41100 Klang, Selangor Darul Ehsan.
Tel: 03-3373 5005, 3374 5005 Fax: 03-3372 4898

SENARAI SEMAK PERMOHONAN UNTUK RAWATAN HEMODIALISIS

Setiap dokumen berikut perlu dikemukakan kepada Dialisis Center dalam 1 Salinan;

- | | | |
|---|--|--------------------------|
| 1 | Borang Permohonan Rawatan Hemodialisis (HC/PA)
<i>Application for Haemodialysis Treatment (HC/PA)</i> | <input type="checkbox"/> |
| 2 | Persetujuan Risiko Tinggi Perawatan Hemodialisis
<i>High Risk Consent - Haemodialysis Treatment</i> | <input type="checkbox"/> |
| 3 | Gambar Berwarna Ukuran Passport (2 Keping)
<i>Passport Size Photo in Colour (2 pcs)</i> | <input type="checkbox"/> |
| 4 | Laporan Pemeriksaan Virus Hep B, Hep C, HIV (Sah dalam 3 bulan)
<i>Hep B, Hep C, HIV Viral Screening Report (Valid within 3 months)</i> | <input type="checkbox"/> |
| 5 | Lembaran Maklumat Pesakit / Laporan Perubatan
<i>Patient Information Sheet / Medical Report</i> | <input type="checkbox"/> |

Tambahan di bawah untuk permohonan sebagai Pesakit Tetap sahaja;

- | | | |
|---|---|--------------------------|
| 6 | Salinan Kad Pengenalan
<i>Photocopy of NRIC</i> | <input type="checkbox"/> |
| 7 | Salinan Slip Gaji 2 bulan terkini atau Surat dari Majikan
<i>Photocopy of latest 2 months Payslip or Letter from Employer</i> | <input type="checkbox"/> |
| 8 | Borang Permohonan Bantuan Subsidi Rawatan Hemodialisis (Jika mohon)
<i>Haemodialysis Treatment Subsidy Application Form (If Apply)</i> | <input type="checkbox"/> |
| 9 | Wajib Ujian Darah di buat semasa memulakan rawatan hemodialisis yang pertama di Pusat SJAM-KPS
<i>(Fungsi Hati, Fungsi Buah Pinggang, Kajian Besi, Kiraan Darah Lengkap)</i>
Compulsory Blood Test upon starting 1st Hemodialysis treatment at SJAM-KPS centre
<i>(Liver Function, Renal Function, Iron Studies, Full Blood Count)</i> | <input type="checkbox"/> |



STATION : _____

HC / PA

Yayasan St John Ambulans Malaysia
Kawasan Pantai Selangor
(SJAM-KPS Foundation)



Certificate Number 3196

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PHOTO
 Passport Size

*One photograph &
 photocopy of NRIC*

APPLICATION FOR HAEMODIALYSIS TREATMENT

01. PERSONAL INFORMATION

Full Name : _____
 NRIC No : _____ Sex : Male Female
 Date of Birth : _____ Age : _____ Nationality : _____
 Address : _____

Marital Status : Single Married Others _____
 Tel. No. (H) : _____ (O): _____ (H/P): _____

02. MEDICAL INFORMATION

a) How long have you undergo haemodialysis treatment ? _____ Years.
 b) Who is your regular doctor / specialist ?
 Doctor Name : _____
 Hospital : _____
 c) Currently where are you having your haemodialysis treatment ?
 Centre Name : _____
 Tel. No. : _____
 d) Next of kin name and contact, in case of emergencies :
 Name : _____
 Tel. No. (H) : _____ (O): _____ (H/P): _____

03. FAMILY INFORMATION (for permanent patient application only) (latest 2 month pay slips)

NAME	RELATIONSHIP	SEX	AGE	OCCUPATION	INCOME (RM)
	HUSBAND / WIFE				
	Children				

04. EMPLOYMENT INFORMATION (for permanent patient application only)

Present Employment: _____
Employer's Name : _____
Employer's Address : _____

Tel. No (O): _____ Present Monthly Income : RM _____

(latest 2 month pay slips)

05. DECLARATION

I declare that,

- a) All the particulars given on this form are true and I have not withheld information.
- b) I may be terminated from the dialysis programme,
 - i) If I do not fulfill the rules & regulations of SJAM-KPS Haemodialysis Service.
 - ii) If I withheld any informations required by this form.
 - iii) If I fail to ensure all my haemodialysis related fees been paid promptly.
- c) I will pay the treatment cost of RM _____ until my application of _____ is approved.

Applicant (Signature) : _____ Date: _____

FOR OFFICE USE

- 1 Applying for Visiting Patient Permanent Patient
- 2 Attached Document: Patient Information Sheet High Risk Consent Letter Medical Report
 Others _____
- 3 Viral screening (Hep B, Hep C, HIV) date _____ (within 3 months)
- 4 Start HD date _____ 1,3,5 2,4,6 Shift 1 2 3 m/c no. _____
via IJC AVF BCF Graft Permcath Right Left
- 5 Charges: Treatment RM _____
(Following is for permanent patient application only) Blanket RM _____
- 6 Blood Test (Liver Function, Renal Function, Iron Studies, Full Blood Count) RM _____
- 7 EPO None Eprex Recormon Others _____ iu
- 8 Payment: JPA Zakat SOCSO Govt. Subsidy Self Pay
- 9 Applying: JPA Zakat SOCSO Govt. Subsidy None

Remarks: _____

Interviewed by, _____ Approved by, _____

SRN / AMO _____
Date : _____

Chief Operating Officer _____
Date : _____

SJAM - KPS Haemodialysis Centre Station ()

Date: _____

HIGH RISK CONSENT - HAEMODIALYSIS TREATMENT

I, (Name) _____

(NRIC) _____

the undersigned is having haemodialysis treatments at St. John Ambulans Malaysia - Kawasan Pantai Selangor Haemodialysis Centre (SJAM-KPS Haemodialysis Centre).

I hereby declare that I am also a high risk patient by having other related health problem.

As such, I indemnify SJAM-KPS Haemodialysis Centre should any complications

arise during the haemodialysis treatments and allow to carry out all the emergency treatments to me.

I understand that this consent applies to all SJAM-KPS Haemodialysis Centers.

Patient Signature or Right Thumb Print,

Witness by,

Name :

Name:

NRIC:

NRIC:

*(SJAM-KPS Haemodialysis Staff
are not allowed to become witness)*