

YONG TUAN HENG RENAL FOUNDATION (YTHRF) TOUR FOR KIDNEY PATIENTS APPLICATION FORM



<i>Instruction: To be completed by doctor or dialysis unit staff</i> Where check boxes <input type="checkbox"/> are provided, check (v) one or more boxes. Where radio buttons <input type="radio"/> are provided, check (v) one box only.	Office use (ID)	_____ / _____
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1	Tour Location (Please select one)	<input type="radio"/> Taipei, Taiwan <input type="radio"/> Jakarta, Indonesia
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A. PERSONAL DETAILS

1a	Title (<i>Mr/Mrs/Ms</i>)		1b. Name	
2	MyKad number			
3	Date of Birth (<i>dd/mm/yyyy</i>)	___ / ___ / _____		
4	Language			
5	Home or Postal Address			
6	a. Cell Phone Number		b. Home Phone Number	
7	a. Name of Contactable Relative			
	b. Relationship		c. Cell Phone Number	
8	a. Name Of Attending Person With Patient			
	b. Relationship		c. Cell Phone Number	
9	Name & Address Of Dialysis Unit At Home			
10	a. Name of Nephrologist (<i>Dr.</i>)			
	b. Cell Phone Number		c. Email	
11	Cause of Renal Failure <i>(Please Specify)</i>			
12	Other Medical Problems <i>(Please Specify)</i>			
13	On Dialysis Treatment, Since (<i>dd/mm/yyyy</i>)	___ / ___ / _____		

B. BLOOD TEST SEROLOGY

	Test	Date <i>(dd/mm/yyyy)</i>	Result	
1	Hepatitis B (HBSAg)	___ / ___ / _____	<input type="radio"/> Negative	<input type="radio"/> Positive
2	Hepatitis B (HBSAb)	___ / ___ / _____	<input type="radio"/> Negative	<input type="radio"/> Positive
3	Hepatitis B (HBcAb)	___ / ___ / _____	<input type="radio"/> Negative	<input type="radio"/> Positive
4	Hepatitis C (HCV)	___ / ___ / _____	<input type="radio"/> Negative	<input type="radio"/> Positive
5	Hepatitis C RNA-PRC HVC	___ / ___ / _____	<input type="radio"/> Negative	<input type="radio"/> Positive
6	HIV	___ / ___ / _____	<input type="radio"/> Negative	<input type="radio"/> Positive

7	MRSA Swabs		
a.	Nose	___/___/_____	<input type="radio"/> Negative <input type="radio"/> Positive
b.	Groin	___/___/_____	<input type="radio"/> Negative <input type="radio"/> Positive
c.	Throat	___/___/_____	<input type="radio"/> Negative <input type="radio"/> Positive
d.	Any Wounds	___/___/_____	<input type="radio"/> Negative <input type="radio"/> Positive
8	Hb	___/___/_____	_____ (g/dL)
9	Urea	___/___/_____	_____ (mg/dL)
10	Potassium (K)	___/___/_____	_____ (mmol/L)
11	Se Calcium	___/___/_____	_____ (mg/dL)
12	Phosphorus	___/___/_____	_____ (mg/dL)
13	ALT / ALAT / SGPT	___/___/_____	_____ (u/L)
14	AST / SGOT	___/___/_____	_____ (u/L)
15	Please Include Any Copies Of Latest Lab Report : Hepatitis B (<i>HbsAg, AntiHBS or AntiHBC</i>), C, HIV and MRSA Blood Test Results		
16	Known Allergies (Please Specify)		

C. DIALYSIS DETAILS

1	Type	<input type="radio"/> HD	<input type="radio"/> HDF
2	Dialysis Duration (Hours)		3. Frequency (Weeks)
4	Access Type	1a. Access Type	<input type="radio"/> AV Fistula <input type="radio"/> Graft <input type="radio"/> Other_____
		1b) Left	
		1c) Right	
		1d) Needle Size	
		1e) Gauge	
		2a) Permanent Catheter	
		2b) Heparin Lock Volume	Result A _____ ml
5	Dialyser		
6	Dialysate Flow		
7	Dialysate	Result Potassium (K)	Result Calcium (Ca)
		_____ (mmol/L)	_____ (mg/dL)
8	Low Molecular Weight Heparin	a. Generic Name	
		b. Dose	

9	Sodium Heparin	a. Initial Bolus	_____ (u)	
		b. Hourly	_____ (u)	
		c. Continuously	_____ (u/hour)	
10	Blood Flow	_____ (ml/min)		
11	Average Intake On Dialysis	_____ (ml)		
12	a. Height	_____ (m)	b. Weight	_____ (Kg)
13	Dry Weight	_____ (Kg)		
14	Average Interdialytic Gain	_____ (Kg)		
15	Blood Pressure	Pre		Post
		_____ / _____		_____ / _____

D. DIALYSIS PROBLEMS

1	Symptoms	<input type="checkbox"/> Hypotension	
		<input type="checkbox"/> Cramps	
		<input type="checkbox"/> Other, Specify: _____	
2	Details	_____	
3	Last Result For Dialysis Adequacy	<input type="checkbox"/> a. Kt/V	_____ (?)
		<input type="checkbox"/> b. URR	_____ %
		c. Date (dd/mm/yyyy)	___ / ___ / _____
4	Current Medication (Please Include Brand Names and Generic Names of Drugs)	a. i) EPO: dose	_____ ii) Frequency
		b. Antihypertensives	_____
		c. Phosphate Binders	_____
		d. Others, Specify	_____
5	History and Physical-Special Requirements	_____	
6	Other Relevant Information	_____	
7	Transplant List (if applicable)	Date of Transplant (dd/mm/yyyy)	___ / ___ / _____

E. APPLICATION BY PATIENT


I hereby confirm that I would like to participate in the tour and agree to the terms and conditions set forth in the Form B.

Name of Patient :	_____		
Date (dd/mm/yyyy):	___ / ___ / _____	Sign:	_____

F. APPLICATION REVIEWED AND APPROVED BY DIALYSIS CENTRE

I hereby certify that I have reviewed and approved patient's fitness to travel as of date stated below.

Name of Doctor in charge:	_____	MMC No:	_____
Date (dd/mm/yyyy):	___ / ___ / _____	Chop & Sign:	_____

G. Payment Information Upon Approval		
1	a. YTHRF Associate Membership Fees (Annual Renewal):	RM 10.00
	b. Tour Fees:	
	Taipei, Taiwan : [] RM 4,488 / patient [] RM 3,988 / dependent	Total RM: _____
	Jakarta, Indonesia: [] RM 2,388 / patient [] RM 1,988 / dependent	Total RM: _____
	TOTAL (RM) (1a+1b)	
2	<p>Payment info</p> <p>All payments are to be made in favour of: Yong Tuan Heng Renal Foundation Direct Payment or Telegraphic Transfer (please include all service charges) to: Bank: UOB MALAYSIA Account No.: 2203033720 Beneficiary: YONG TUAN HENG RENAL FOUNDATION Reference for Taipei Tour: Taipei Tour and membership Reference for Jakarta Tour: Jakarta Tour and membership</p>	
3	Checklist Documents to attach :	
	Stage 1 - Application	
	<input type="checkbox"/> Form A – Application form (this form) – completed by dialysis centre; signed by patient and doctor	
	<input type="checkbox"/> Form B – Terms and Conditions of Participation – signed by patient	
	<input type="checkbox"/> Please Include Any Copies Of Latest Lab Report : Hepatitis B (HbsAg, AntiHBS or AntiHBC), C, HIV and MRSA Blood Test Results	
	<input type="checkbox"/> Yong Tuan Heng Renal Foundation (YTHRF) Membership Registration. To join as member, scan the QR Code (right) or go to https://tinyurl.com/ythrfmember to complete the Yong Tuan Heng Renal Foundation Membership Registration form.	
	<input type="checkbox"/> Payment Slip – YTHRF Membership fees	
	<input type="checkbox"/> Payment Slip – 50% Tour fees <u>Important Notice</u> <i>Only members who have paid the membership fee are entitled to apply.</i> <i>Application will be submitted to our panel doctors for evaluation and approval upon payment of the deposit. The deposit will be fully refunded for unapproved applications (or in the event of cancellation by the organisers). Unsuccessful applicants will be informed in writing. Deposit paid will be considered as part payment for successful applications. Please note there is a no cancellation policy for applicants.</i> <i>*Deposits will not be refunded in the event of cancellation by applicants after the application is submitted.</i> <i>* Note: All applications will be forwarded for medical consideration. Cost will be incurred to process the application hence the non-cancellation policy. Flight and tour arrangements will be made automatically for all approved applications without further notice. Applicants will only be notified of the flight and tour itinerary once the flight arrangements are finalised.</i>	
	Stage 2 – Upon approval of application – to be informed by YTHRF	
	<input type="checkbox"/> Payment Slip – 50% Balance Tour fees (Upon approval)	
	Stage 3 – To be submitted 14 days and 3 days prior to tour date	
	<input type="checkbox"/> Form C – Pre Admission COVID-19 Form	

H. For Office Use Only

A) Verified and approved by YTHRF Medical Director

1.	Name of Doctor :	Dr Fan Kin Sing	MMC No:
	Date:	____ / ____ / _____	Chop & Sign:

B) Verified and Approved by Receiving Dialysis Centre at Tour Destination (RDCTD)

1	Name of Doctor:		Chop & Sign:
	Date:	____ / ____ / _____	

Tour Application Flow

