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
Email: dialysis@sjamsde.org.my

SENARAI SEMAK PERMOHONAN UNTUK RAWATAN HEMODIALISIS

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

1 Borang Permohonan Rawatan Hemodialisis (HC/PA) ☐
Application for Haemodialysis Treatment (HC/PA)

2 Persetujuan Risiko Tinggi Perawatan Hemodialisis ☐
High Risk Consent - Haemodialysis Treatment

3 Gambar Berwarna Ukuran Passport (2 Keping) ☐
Passport Size Photo in Colour (2 pcs)

4 Laporan Pemeriksaan Virus Hep B, Hep C, HIV (Sah dalam 3 bulan) ☐
Hep B, Hep C, HIV Viral Screening Report (Valid within 3 months)

5 Lembaran Maklumat Pesakit / Laporan Perubatan ☐
Patient Information Sheet / Medical Report

Tambahan di bawah untuk permohonan sebagai Pesakit Tetap sahaja;

6 Salinan Kad Pengenalan ☐
Photocopy of NRIC

7 Salinan Slip Gaji 2 bulan terkini atau Surat dari Majikan ☐
Photocopy of lastest 2 months Payslip or Letter from Employer

8 Borang Permohonan Bantuan Subsidi Rawatan Hemodialisis (Jika mohon) ☐
Haemodialysis Treatment Subsidy Application Form (If Apply)

9 Ujian Darah Wajib dibuat semasa rawatan hemodialisis yang pertama dimulakan di Pusat SJAM-KPS ☐
Compulsory Blood Test upon starting 1st Hemodialysis treament at SJAM-KPS centre

Blood Test Code (Blood Test Lab) :

New Patient : SJAM5 (Gribbles) or SJAM3 + ABO (BP Lab)

New Patient (Diabetes) : SJAM6 (Gribbles) or SJAM4 + ABO (BP Lab)

Issue Date : 15/02/2023

STATION : _____ HC / PA

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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 : _____

_____

Email : _____

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):** _____

Email : _____

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 witheld 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* ☐ *High Risk Consent Letter* ☐ *Medical*
☐ *Other* _____

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 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 _____ Chief Operating Officer

Date : Date : _____

SJAM - KPS Haemodialysis Centre Station ( )

_____

_____ Date: _____

HIGH RISK CONSENT - HAEMODIALYSIS TREATMENT

I, _____

(NRIC) _____ is a high risk patient, have related health problem and I have been advised by the centre Doctor on the risk of haemodialysis treatment. Hereby, I give my consent to receive haemodialysis treatment and accept the risk involved. If any complication arise during my haemodialysis, emergency procedure/ treatments be applied to me that is deemed necessary. Having understood the risks involved, I agreed not to hold Yayasan St John Ambulans Malaysia - Kawasan Pantai Selangor (SJAM-KPS Foundation) and their staff responsible if I suffer from any complication, injury or death resulting during the haemodialysis treatment.

Patient Signature or Right Thumb Print,

Witness by,

_____ _____

Name :
NRIC
Date :

Name:
NRIC
Date :
(family members / relatives)

_____

Name of Doctor :

Issue Date : 01/07/2022

STATION : _____ HC / MR

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MEDICAL REPORT FOR HAEMODIALYSIS TREATMENT

(To be Completed by Applicant's Doctor)

1. **Name Of Patient** : .....
   NRIC : .....
   Date of Birth : .....
   Address : .....
   .....
   .....

2. **Current Haemodialysis Treatment :**

   Date of First Dialysis : .....
   Mode of Access ☐ **IJC** ☐ **AVF/BCF** ☐ **Others** .....
   Place of Current Dialysis : .....
   : .....
   Problems During Dialysis : .....

3. **Current Medications :**

4. Medical Conditions (Summary) :

- **Diabetes Mellitus** ☐
- **Hypertension** ☐
- **Coronary Artery Disease** ☐
- **Cerebrovascular Disease** ☐
- **Peripheral Vascular Disease** ☐
- **Is the Patient Mentally Disorder ?** ……..……....
- **Others**

……
……
……
……
……
……

5. Blood Analysis **(Kindly provide latest Blood Test Report, if possible)**

Blood Group	**A** ☐	**B** ☐	**AB** ☐	**O** ☐		
HB (%)	: …….	g/dl				
Urea	: …….	mmol/L				
Creatinine	: …….	umol/L				
Potassium	: …….	mmol/L				
Hbs Ag	**Reactive** ☐		**Non-Reactive** ☐		**Not-Done** ☐	
Hbs Ab	**Reactive** ☐		**Non-Reactive** ☐		**Not-Done** ☐	
HCV AB	**Reactive** ☐		**Non-Reactive** ☐		**Not-Done** ☐	
VDRL	**Reactive** ☐		**Non-Reactive** ☐		**Not-Done** ☐	
MRSA	**Reactive** ☐		**Non-Reactive** ☐		**Not-Done** ☐	

……..…… **……..**

Signature & Chop Of Nephorologist / Physician

Date :