Clinical Information Form

(For Funding Application)

To be filled up by the refering Physician

Name of patient

Date of Birth

I/C or Mother's IC

Place of treatment

Diagnosis : 1

2

3

4

5

Indications for ventilatory / oxygen support

1

2

3

4

Type of equipment applied :

i) CPAP ☐

ii) BIPAP ☐

iii) Oxygen ☐

Others (Please state) :

Lung Foundation of Malaysia
Office Suite 2-3, 2nd Floor, Medical Academies of Malaysia, 210, Jalan Tun Razak, 50400 Kuala Lumpur.
Tel/Fax: **603 - 4025 2700** • email : **lungfoundation@gmail.com**