

Clinical Information Form

(For Funding Application)

To be filled up by the referring 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

Ventilory / oxygen dependency

i) 24 hours

ii) Sleep and part of the day

iii) During sleep

Duration of support :

i) Lifetime

ii) Temporary improve with time

Name of referring Physician

Address

Phone (office)

(handphone)

Email address

Signature

Please submit a summary of applicant's medical report

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