# Gamma Knife Charitable Fund Assessment Form

Reference No: _____ Date: _____

**Please download and read the guidance notes for Gamma Knife Charitable Fund Application before filling in this form. If you need assistance, please contact us at 6280-2752.**

## A. Patient's Personal Data

| | | | |
|---|---|---|---|
| Name in English | | | |
| Name in Chinese | | I/D# | |
| Date of Birth (dd/mm/yy) | | Gender | * Male / Female |
| Marital Status | * Single / Married / Divorced / Widow / Widower | | No. of Children : |
| Residential Address | | | |
| Phone Number | (Home) | (Mobile) | (Others) |
| Job Position | | | |
| Name of Employer | | | |
| Current Monthly Salary | | | |
| Referral Source | * Self / Private Doctor / Government Doctor / NGO | | |
| Referrer details | | | |

**Household Members Personal Data** (You are required to provide complete and accurate information regarding all household members, without omission or misrepresentation.)

| Relationship with patient | Name | Gender | Age | Marital Status | Total Monthly Income (1) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Others:** .....

.....

(1) Total monthly income of at least 6 months should include salary, pension, regular financial contribution from relatives or friends "not" living together; and income from assets and/or properties of the patient.

* Please delete where appropriate

Patient's Name: _____ Ref. No.: _____

## B. Financial Assessment

| **Financial Income and Expenditure** | **Amount (HK$)** |
|---|---|
| Total Household Monthly Income | |
| Total Household Monthly Expenditure<br>(e.g. mortgage, electricity, gas or water bill) | |

| **Total Household Assets** | **Amount (HK$)** |
|---|---|
| Available bank savings | |
| Other assets e.g. stocks, shares, insurance, etc | |
| **Total:** | |

1. Please briefly explain your current financial situation and challenges you are facing that make it difficult to pay for treatment cost: .....

   .....

2. Do you have private health insurance that may cover part of treatment cost? .....

   .....

3. Are you seeking financial support from other organizations, charities or funds for medical expenses? (YES / NO)

   If yes, please specify .....

4. Recipient of Social benefits (if any)

   (CSSA / Others _____) Case No. _____

***Declaration:*** By submitting this questionnaire, I confirm that the information provided are accurate to the best of my knowledge. I understand that the information provided will be used for the purpose of assessing eligibility for the Gamma Knife Charitable Fund (GKCF) subsidy. Acquiring GKCF assistance by deception is a criminal offence, the patient/the applicant/the patient's household members shall be include to on conviction to imprisonment under the theft ordinance (chapter 210 of the laws of Hong Kong).

_____ _____

* Signature / guardian / appointee

* Signature & Name of Witness

* Please delete where appropriate

Patient's Name: _____ Ref. No.: _____

## C. To be completed by referring Doctor

| | |
|---|---|
| Diagnosis | |
| Date of diagnosis | |
| No. of Brain Met and locations (if applicable) | |
| Primary cancer (if applicable) | |
| Previous Treatment (specify if any) | RT / Chemotherapy / Operation / Others |
| Presenting Symptoms/Signs | |
| Clinical Status | |
| Karnofsky Scale | |
| Comments from Referring Doctor | |

Referring Doctor Name: _____

Address: _____

Contact No.: _____ Signature: _____

* Please delete where appropriate