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 (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 liable 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 fax the duly completed application form to 2522 2663 for processing.

* Please delete where appropriate