



ADOOR DIOCESE DIALYSIS SUPPORT

MARTHOMA SYRIAN CHURCH, ADOOR DIOCESE, DIALYSIS MEDICAL AID PROJECT

Patient Information Form

This form is to be filled out by the parish vicar in consultation with the dialysis patient and their family. The information provided will be kept confidential and used solely for the purpose of evaluating support through the Adoor Diocese Dialysis Assistance Program.

PERSONAL INFORMATION

1. Parish Name :
2. Patient Full Name :
3. Age :
4. Gender :
5. Phone Number :
6. Permanent Address :

MEDICAL PROFILE

7. Are you currently undergoing dialysis? : Yes/ No
8. Frequency of dialysis per week :
9. Name of the hospital where dialysis is done
10. Do you receive any other dialysis support (Govt or Private)? : Yes/ No
11. If Yes, please specify the program name and amount you are receiving
12. Are you covered under any insurance plan provided by the hospital where you are receiving dialysis? Yes/ No

13. If Yes, please specify the insurance name and amount you are receiving

14. Number of family members living in the household :

15. Monthly Family Income :

16. How many members of the family are currently employed?

17. Do you need financial support to continue dialysis treatment? : Yes/ No

18. Are you able to contribute towards a portion of your treatment cost? Yes/ No

If yes, please specify the approximate percentage or amount you can manage.

19. Are you currently undergoing medical treatment for any other diseases or health conditions? Yes/ No (If yes, please specify.)

Submit : Medical Certificate (Proof of Treatment), ID Proof (Aadhaar, Voter ID etc.)

I hereby declare that the above information is true to the best of my knowledge.

Vicar Name :

Date :



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