



# CHILDREN'S KIDNEY FUND

## 兒童腎病基金

Shop 25, G/F, Peninsula Apartments, 16 Mody Road, Tsim Shg Tsui, Kowloon

九龍尖沙咀麼地道 16 號半島大廈地下 25 號舖

Tel : 2 3 6 9 4 9 2 8

Website: <http://www.childrenkidneyfund.org.hk>

### 『依庫珠單抗藥資助計劃』

#### Subsidy for Eculizumab

#### 資助申請表格

#### Application Form

請將填妥表格及主診醫生推薦信一併電郵至 [info@childrenkidneyfund.org.hk](mailto:info@childrenkidneyfund.org.hk)。正本請郵寄至以上地址

Please email the completed form together with recommendation letter from the case doctor to [info@childrenkidneyfund.org.hk](mailto:info@childrenkidneyfund.org.hk).

For hard copy applications, please send the documents to the captioned address by post.

#### 1. 申請人（病童）資料

##### Information on Applicant (Patient)

|                                                                   |         |               |
|-------------------------------------------------------------------|---------|---------------|
| 姓名：                                                               | (中)：    | 性別：           |
| Name                                                              | Chinese | Sex           |
|                                                                   | (英)：    | 出生日期：         |
|                                                                   | English | Date of Birth |
| 出生證明書 / 身份證號碼* (請刪去不適用者):                                         |         |               |
| Birth Certificate / Identity Card No. * (Delete as Inappropriate) |         |               |
| 居住地址：                                                             |         |               |
| Residential Address                                               |         |               |
|                                                                   |         | 電話：           |
|                                                                   |         | Tel. No.      |

#### 2. 申請人父母／監護人資料

##### Information on Parent / Guardian

|                             |         |                   |
|-----------------------------|---------|-------------------|
| 姓名：                         | (中)：    | 性別：               |
| Name                        | Chinese | Sex               |
|                             | (英)：    | 身份證號碼：            |
|                             | English | Identity Card No. |
| 與申請人關係：                     |         |                   |
| Relationship with Applicant |         |                   |
| 聯絡地址：                       |         |                   |
| Contact Address             |         |                   |
| 聯絡電話：(日)                    |         |                   |
| Tel. No. Daytime            |         |                   |
| (夜)                         |         |                   |
| Evening                     |         |                   |

### 3. 轉介醫生聲明

#### Declaration of the referring doctor

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                    |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| 申請人所患疾病：<br>Diagnosis of the Applicant:                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                    |
| 需要依庫珠單抗治療原因：<br>Indications of Eculizumab:<br>(Must check both boxes) | <input type="checkbox"/> Evidence of active and progressing thrombotic microangiopathy<br>- Platelet count $<150 \times 10^9/L$ AND<br>- Hemolysis as evidenced by schistocytes / low haptoglobin / high LDH<br>- OR Tissue biopsy confirming TMA in patients without evidence of hemolysis or platelet consumption<br><input type="checkbox"/> Major Organ Involvement<br><input type="checkbox"/> Kidney<br><input type="checkbox"/> Central nervous system<br><input type="checkbox"/> Cardiac<br><input type="checkbox"/> Gastrointestinal<br><input type="checkbox"/> Pulmonary |                                                                    |
| 以往曾用治療：<br>Previous drug(s) used:<br>(Please ✓)                       | <input type="checkbox"/> Steroid<br><input type="checkbox"/> Cyclophosphamide<br><input type="checkbox"/> Plasmapheresis<br><input type="checkbox"/> Others (Please specify) _____                                                                                                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> MMF<br><input type="checkbox"/> Rituximab |

茲證明上述申請人需接受依庫珠單抗治療，此次治療每次藥量為 \_\_\_\_\_ mg，推薦接受有關藥物費用資助。

This is to certify that the Applicant needs to receive Eculizumab with treatment dosage of \_\_\_\_\_ mg for \_\_\_\_\_ times.

Subsidy on the drug cost is recommended.

以前有否接受兒童腎病基金資助？

Has the applicant received subsidy from Children's Kidney Fund before?

☐ 有 Yes      ☐ 沒有 No

如「有」，請註明：

If yes, please specify:

日期 Date: \_\_\_\_\_

資助形式 Form of subsidy: \_\_\_\_\_

轉介醫生姓名：

Name of Referring Doctor

(中)

Chinese

(英)

English

簽署：

Signature

轉介日期：

Date of Referral

所屬醫院及地址：

Name of Hospital & Address

電話：

Tel. No.

#### 4. 付款辦法

- ☐ 申請人先向醫院繳付費用，再提交醫院藥費收據正本，領取基金資助  
Reimbursement on production of official receipts from the hospital
- ☐ 由基金向醫院直接繳付有關費用  
The Fund to settle the cost directly with the hospital

## 5 醫務社工審核

## Assessment of Medical Social Worker

申請人家庭每月總收入（港幣）：

Total Family Income (HK\$)

家庭總收入與政府所訂「家庭住戶每月入息中位數」比例： % of Total Family Income at MMHDI

- ☐ 100%或以下  
100% or below
- ☐ 100-130%之間  
Between 100-130%
- ☐ 130%以上  
Above 130%

醫務社工姓名：(中)

Name of MSW

Chinese

(英)

English

簽署：

Signature

認可日期：

Date of Endorsement

所屬醫院：

Name of Hospital

聯絡地址：

Address

電話：

Tel. No.

## 6. 申請人聲明

### **Applicant's Declaration**

茲証實上述資料無誤。

I declare that the above information is rightful and correct.

申請人(年齡十二歲以上者) 簽署：

Signature of Applicant (For age 12 or above)

父母 / 監護人簽署：

Signature of Parent / Guardian

收款人 (基金發放支票抬頭人) 姓名：

Name of Cheque Recipient

簽署式樣：

Specimen Signature

申請日期：

Date of Application

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**以下由基金工作人員填寫 (For Office Use Only) :**

收件日期 :

Received Date

收件人簽署 :

Signature of Receiving Officer

核准人簽署 :

Approved by

日期 :

Date

檔案編號 :

Reference No.

備註 :

Remarks

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附註 :

NOTES

1. 依庫珠單抗資助計劃津貼，如病者家庭每月總收入於「家庭住戶每月入息中位數」百分之一百或以下，資助金額上限為港幣七萬正。如家庭每月總收入介乎「家庭住戶每月入息中位數」百分之一百至一百三十之間，資助金額上限為港幣五萬元正。  
**For patients with total family income 100% of the Median Monthly Domestic Household Income (MMDHI) or below, subsidy level of Eculizumab is capped at HKD\$70000. For those with total family income between 100-130% of MMDHI, the subsidy level is capped at HKD\$50000.**
2. 家庭每月總收入在「家庭住戶每月入息中位數」百分之一百三十以上，將不獲資助。  
**For patients with total family income above 130% of the Median Monthly Domestic Household Income (MMDHI), no subsidy would be approved.**
3. 申請人年齡必須在 21 歲或以下，由香港兒童醫院醫生推薦，並經醫務社工審核家庭收入。  
**The applicant's age must be 21 years or below, with recommendations from medical doctors of the Hong Kong Children's Hospital and an assessment of family income by a medical social worker.**
4. 每次申請的有效期為批核後的兩個月。  
**Each application is only valid for 2 months after it is approved.**