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

『瑞利珠单抗藥資助計劃』
Subsidy for Ravulizumab

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 。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.
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 _____
出生証明書 / 身份証號碼* (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）： 身份証號碼：
English _____ Identity Card No. _____
與申請人關係：
Relationship with Applicant _____
聯絡地址：
Contact Address _____
聯絡電話：(日) (夜)
Tel. No. Daytime _____ Evening _____

3. 轉介醫生聲明
Declaration of the referring doctor

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

茲証明上述申請人需接受瑞利珠單抗治療，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 Ravulizumab 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「家庭住户每月入息中位數」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 _____

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 _____

_____

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「家庭住户每月入息中位數」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「家庭住户每月入息中位數」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「家庭住户每月入息中位數」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.