



**APPLICATION FORM TO SEEK ASSISS WOUND CARE SERVICES (AWCS)**

ASSISS is committed to delivering services to those who are genuinely poor and in need of medical services (*certain medical conditions are excluded*), provided that the services are available at Assunta Hospital/ ASSISS. Kindly note that only application forms accompanied by the supporting documents (where applicable) listed below will be considered.

1. NRIC copy (patient & family members).
2. Letter from employer certifying salary, salary slips or bank statements (3 months) of patient & carer who are working).
3. Valid medical certificate (if applicable).
4. Any other supporting documents that are deemed helpful for ASSISS to understand the family situation.

The decision of the ASSISS Committee is final.

**Section A: Patient Information**

Diagnosis: \_\_\_\_\_

Mobility: Independent without aid/ Independent with aid/ Wheelchair-bound/ Bedridden

Patient's Name: \_\_\_\_\_

NRIC: \_\_\_\_\_

Sex: Male/ Female      Age: \_\_\_\_\_

Number of Children: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_

Mobile Number: \_\_\_\_\_

Marital Status: Single/ Married/ Separated/ Divorced/ Widowed

**FAMILY INCOME INFORMATION**

NAME	AGE	SEX	RELATIONSHIP	OCCUPATION	NAME OF COMPANY	MONTHLY GROSS INCOME
			SELF			
<b>TOTAL:</b>						

I, .....(IC#.....), .....(relationship) of the patient, hereby declare that all of the information provided above is true and accurate to the best of knowledge. I understand that the information is used to assess patient's eligibility for ASSISS Palliative Service and the submission of the application does not guarantee the provision of the service. The Committee reserves the right to use and disclose all information contained herein to a third party if there is a need.

Signature:

Mobile #:

Date:

\*\*\*FOR ASSISS USE ONLY\*\*\*

**INTERVIEW OF PATIENT / FAMILY MEMBERS**

**REFERRAL SOURCE** : GOVERNMENT HOSPITAL / NGO / SELF / RENEWAL / OTHERS: \_\_\_\_\_

**INTERVIEW LOCATION** : PATIENT'S HOME / ASSISS OFFICE / ASSUNTA HOSPITAL / OVER THE PHONE

**INTERVIEW DATE** :

**PERSONS INTERVIEWED:**

- |    |                             |
|----|-----------------------------|
| 1. | RELATIONSHIP WITH PATIENT : |
| 2. | RELATIONSHIP WITH PATIENT : |
| 3. | RELATIONSHIP WITH PATIENT : |

**GENOGRAM:**

**RECOMMENDATION:**

*(For borderline cases, a detailed social report will be attached.)*

**INTERVIEW CONDUCTED BY:**

**NAME :**

**DESIGNATION :**

**NAME :**

**DESIGNATION :**

**DECISION BY ASSISS COMMITTEE**

**APPROVED**

**NOT APPROVED**

**REMARKS :**

**CONFIRMED BY :**

\_\_\_\_\_  
**NAME :**

**DESIGNATION :**

**DATE :**

**MEETING DATE:**

**MEETING CONDUCTED BY:**

**NAME:**

**DESIGNATION:**