

CDC GROUP OF COMPANIES

Branch: _____

REGISTRATION FORM

Today's Date:		Registration number:		
PATIENT INFORMATION				
Patient name:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Madam	<input type="checkbox"/> Datuk <input type="checkbox"/> Datin
Marital status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/>		Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Nationality: Malaysian <input type="checkbox"/> Others <input type="checkbox"/> _____		Race: Malay <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Others <input type="checkbox"/> _____		
Street address:		Hand phone no.:	Home phone no.: ()	
City:		State:	Post Code:	
Occupation:		Employer:	Office phone no.: ()	
Chose clinic because/referred to clinic by (Please check one box):		<input type="checkbox"/> Dr.		
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Hospital
<input type="checkbox"/> Insurance plan		<input type="checkbox"/> Other _____		

MEDICAL INFORMATION

(Private and confidential)

On dialysis before? <input type="checkbox"/> Yes <input type="checkbox"/> No		Since :	If yes, where?		
Previous dialysis centre	Previous dialysis centre address:		Previous dialysis centre phone no.: ()		
Cause of End Stage Renal Failure (ESRF)					
Mode of dialysis	<input type="checkbox"/> AVF	<input type="checkbox"/> BCF	<input type="checkbox"/> BBF	<input type="checkbox"/> IJC	<input type="checkbox"/> Permanent catheter
Mobilization <input type="checkbox"/> Independent <input type="checkbox"/> Wheelchair		How many times per week on dialysis?			
		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Erythropoietin <input type="checkbox"/> Yes <input type="checkbox"/> No					
INVESTIGATIONS					
Hepatitis B <input type="checkbox"/> Non-reactive <input type="checkbox"/> Reactive		Hepatitis C <input type="checkbox"/> Non-reactive <input type="checkbox"/> Reactive		HIV <input type="checkbox"/> Non-reactive <input type="checkbox"/> Reactive	

IN CASE OF EMERGENCY

Name of local friend or relative :		Relationship to patient:	Contact phone no.: ()
The above information is true to the best of my knowledge.			
_____ <i>Patient/Guardian signature</i>		_____ <i>Date</i>	