LFM- Clinical Information Form

for funding application
***To be filled up by the referring Physician**

Patient name:

Parent name (for paeds patient):

Patient NRIC:

Parents NRIC (for paeds patient):

Date of birth:

Place of treatment:

Name of Respiratory Consultant:

Email:

Phone number:

Address:

Diagnosis:

Indication for ventilatory/oxygen support:

Type of Equipment applied:

☐ CPAP ☐ BiPAP ☐ Oxygen Concentrator

☐ Others

Ventilatory/oxygen dependency:

- [ ] 24 Hours
- [ ] Sleep & part of the day
- [ ] During sleep

Duration of support:

- [ ] Lifetime
- [ ] Temporary improve with time

Please submit a summary of applicant's medical report. The medical report must be signed or verified by the respiratory consultant in charge.