Living Free To Live

STAY HOPEFUL...FIND YOUR PURPOSE

APPLICATION FORM

SECTION A: BIODATA

1. Name: …….....……

2. Age: …….....…..... Date of Birth: ……..…

3. Sex: M ☐ F ☐

4. Address: ….....……..……

5. Mobile number: …… WhatsApp number: ……....

6. Email Address: …….....

7. Occupation: …….....……..……..

8. Company where employed: …….....

   Position held at company: ……. Income per month: ……..…...…….

   If private business owner, then sales turn over per month: …….....…….

9. If Student, name of school being attended: …….....…....

SECTION B: MEDICAL HISTORY

1. When were you diagnosed of Myasthenia Gravis (MG)? …….....……...…

2. What type of Myasthenia Gravis (MG) were you diagnosed with?

   AChR type ☐ AtiMuSK type ☐ Unknown ☐

3. Name of hospital where diagnosis was made: …….....……....

4. Name of diagnosing/treating physician: …….....…….....

5. What medication are you on? List them all.

SECTION C: TO BE COMPLETED BY THE ATTENDING PHYSICIAN

1. Name of attending physician: …….....…….

2. Mobile number: …….....…. WhatsApp number: ……..….....….

3. Email address: …….....…….

4. Name of Neurologist in-charge (Consultant/Specialist): …….....…….

5. Does the patient attend reviews regularly?

   Yes ☐ No ☐

6. Is the patient compliant with medication?

   Yes ☐ No ☐ Unknown ☐

7. Other comments about the patient

8. Signature: .....

   Date: …….....……

SECTION D: FOR OFFICIAL USE

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