Table 5

Attached Form to the Application Form for the Certificate of Major Illness and Injury Applied by Respiratory Patient

□ New application □ Replacement of card

Name: _____ Gender: □ Male □ Female

Date of birth: _____YY_____MM____DD Number of national identification card:_____

Hospital where the patient currently stays: _____ Hospital

A. Currently at：(Date of transfer to the department：_____YY_____MM____DD)

□ICU Intensive care unit □RCC Subacute respiratory care center □RCW Chronic respiratory care ward

□General ward □HC Home care

B. Date of first-time admission to the ICU：_____YY_____MM____DD

□ICU of this hospital □ICU of other hospital（Name：_____）

Date of transfer from the ICU：_____YY_____MM____DD

C. Diagnoses：（Primary cause of respiratory failure）_____

Other diagnoses：

1)_____

2)_____

D. Use of mechanical ventilation：Start date_____YY_____MM____DD，Duration：____ days

（If the patient is off the mechanical ventilation for more than 5 days, the date of using the ventilator again will be counted as the start date）

Current status of mechanical ventilation：

□Attached copy of daily respiratory therapy report for the past 21 days

□Attached copy of daily respiratory therapy report for the past 30 days

1) Active treatment to assist patient to become independent of ventilator（ Please specify date and method ）:

_____

_____

2) Supportive care ONLY （ Please specify ）: _____

_____

E. After evaluation by the physicians of the pulmonary and critical care medicine, the following locations are appropriate for patient care：

□ICU Intensive care unit □RCC Subacute respiratory care center □RCW Chronic respiratory care ward

□General ward □HC Home care

Physician of pulmonary and critical care medicine_____ Pulmonary Specialty (License) No. _____ Signature_____

Date of evaluation: _____YY_____MM____DD

---------- The column below shall be filled out by the review physician only -- ----------

To: M.D. _____

Review opinion: 1)□ Approve to issue the certificate of major illness and injury

2)□ Disapprove because the applicant fails to satisfy the criteria. Ground:_____

_____

3)□ Please submit the supplementary documents for review of the application. _____

_____

_____

Review physician: _____ Signature/seal:_____ Date: ____YY____MM____DD

---The column below shall be filled out by the National Health Insurance Administration, Ministry of Health and Welfare only---

Division:

Date of application acceptance:_____

Application No.: _____