|  |  |  |  |
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|  | **National Renal Registry** | *For office use:* |  |
| **Malaysian Society of Nephrology** | *Telephone* | 603-22763686  603-22763687 |
| **Centre Information Update (Borang 5)** | *e-mail* | [nrr@msn.org.my](mailto:nrr@msn.org.my) |

*Kepada yang menjaga:*

* *Isikan borang ini dengan lengkap dan pulangkan kepada [nrr@msn.org.my](mailto:nrr@msn.org.my). Tandakan maklumat yang perlu digantikan/kemaskini. Pusat HD swasta perlu lampirkan satu salinan lesen CKAPS*
* *Setiap staf berdaftar dengan eNRR sekali sahaja. Ini adalah akaun anda; akaun yang ini akan digunakan jika anda ada tambahan pusat atau pun sudah pindah ke pusat yang lain. Maklumat peribadi, nombor telefon bimbit dan emel staf adalah wajib.*
* *Staf yang berkelulusan bidang perubatan atau para-perubatan sahaja yang boleh mengendalikan maklumat-maklumat pesakit.*
* *Infomasi pusat dan staf yang dinamakan di borang ini nama anda akan tertera di Directory* <https://www.msn.org.my/nrr/centre_directory.jsp>. *Anda berkuasa menambahkan atau mengeluarkan penguna eNRR pusat anda..*
* *Jika terdapat ada perbezaan maklumat pusat, pusat ini akan diminta buat pendaftaran baru.*

**Pilihkan perkhidmatan yang berkaitan untuk kemasakini** *(Pusat HD swasta perlu lampirkan satu salinan lesen CKAPS)*

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Treatment service centre:** |  | HD |  | CAPD |  | Tx |  | Renal biopsy |

# **1 Centre information** *(Isi gunakan komputer. Jangan tulis )*

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Haemodialysis centre information: | | | | | | | | | | | | |
| **Centre Name:** | |  | | | | | | | | | | |
| **Classification:** | |  | | ARMED FORCE | |  | MOH | |  | NGO | |  |
|  | | PRIVATE | |  | UNIVERSITY | |  | | | |
| **Centre Address*:*** | |  | | | | | | | | | | |
| Postcode: |  | | City/Town: | |  | | | State: | | |  | |
| ***Tel (1):*** |  | | ***Ext:*** | |  | | | ***Tel (2):*** | | |  | |
| ***Fax:*** |  | | ***e-Mail:*** | |  | | | | | | | |
|  | | | | | | | |  | | | | | |

1. **Key personnel of the centre.**

***(****Genapkan semua maklumat staf sendiri. Berkongsi telefon, emel atau eNRR akaun tidak dibenarkan. Sila isikan siapkah da pelanan manakah yang perlu ditukar)*

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| **i) Doctor in-charge Information *(Name as registered with CKAPS Licensing):*** | | | | | | | | | | | | | | | | | |  |
| ***Name of doctor in-charge:*** | | | | |  | | | | | | | | | *Mykad No:* | |  | | |
| *Mobile phone:* |  | | | | | | | | *e-mail address:* | | |  | | | | | | |
| **Doctor qualification: (Degree/Membership/Fellowship)** | | | | | | | | | | | | | |  | | | | |
| Nephrologist | | | Physician (MD) | | | | | | Medical officer (MBBS) | | | | | Others, specify: | | | | |
| *National Specialist Register No.:* | | | | | |  | | | | | | | |
| *Completed 200 hours training:*  *(A copy of 200 hrs trained certificate needed):* | | | | | | | | *Date start:* | |  | | | *Date completed:* | | | |  | |
| **ii) Affiliated Nephrologist Information:** | | | | | | | | | | | | | |  | | | |  |
| Nephrologist name: | | | |  | | | | | | | | | | *Mykad No:* | |  | | |
| *Mobile phone:* | |  | | | | | | | e-mail address: | | | |  | | | | | |
| *National Specialist Register No.:* | | | | | | |  | | | | Date accredited nephrologist: | | | |  | | | | |  | e-mail address: | …………………………………………… |

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| **iii) Centre Manager Information:** | | | | | | | | | | | | | |  | | |  |
| Name: |  | | | | | | | | | | | | | *Mykad No:* | |  | |
| *Mobile phone:* |  | | | | | | | e-mail address: | | | | |  | | | | |
| Academy qualification: | | | |  | | Medical / paramedical | | | | | |  | | | Non-medical | | |
| If medical staff: | | Registered Nurse | | | | | Registered Medical Assistant | | | | Others, specify: …………………………… | | | | | | |
| **If had Post Basic Renal Nursing :** *(Lampirkan satu salina sijil. Kosongkan jika anda belum ada kelulusan ini)* | | | | | | | | | | | | | | | | | |
| Nursing school name: | | | | |  | | | | | | | | | | | | |
| Date completed training: | | | | |  | | | | |  | | | | | | | |
| **iv) Centre Coordinator Information:** | | | | | | | | | | | | | |  | | |  |
| Name: |  | | | | | | | | | | | | | *Mykad No:* | |  | |
| *Mobile phone:* |  | | | | | | | e-mail address: | | | | |  | | | | |
| Academy qualification: | | | |  | | Medical / paramedical | | | | | |  | | | Non-medical | | |
| If medical staff: | | Registered Nurse | | | | | Registered Medical Assistant | | | | Others, specify: …………………………… | | | | | | |
| **If had Post Basic Renal Nursing :** *(Lampirkan satu salina sijil. Kosongkan jika anda belum ada kelulusan ini)* | | | | | | | | | | | | | | | | | |
| Nursing school name: | | | | |  | | | | | | | | | | | | |
| Date completed training: | | |  | | | | | |  | | | | | | | | |

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| --- |
| Remarks: |

***Staf yang nama tersenarai di director perlu mengesahkan bahawa borang ini adalah benar.***

Name :………………………………………………………..

Designation in the centre: …………………………………....

Date update: …………………………………

***Perhatian!***

* + - 1. *HD swasta, diminta lampirkan gambar lesen CKAPS diborang ini.*
      2. *PIC bukan pakar nefrologi, sila lampirkan sijil ’200 Hours certificate’.*
      3. *Demi PDPA, simpankan fail ini dengan “****Password****” sebelum pulangkan sebagai lampiran kepada NRR.*
      4. *Beritahu “****Password****” untuk buka lampiran ini melalui emel susuran; bukan email yang ada lampiran dokumen ini.*