KULSUM Healthcare Foundation	**KHF Registration and Initial Verification Form**	Code: KHF/P&P/001/FM-01 Version:01 Effective Date: April, 2026

Patient Name: _____

Father/Husband/Guardian Name: _____

Gender (M/F): _____

Date of Birth: _____

Age: _____

Marital Status: _____

CNIC #//B-Form #: _____

Guardian's CNIC # (in case the patient is a minor): _____

Occupation: _____

Designation: _____

Organization: _____

Monthly Income in Rs. (if applicable): _____

Source of Income (in case of unemployment): _____

Number of Dependents: _____

Contact Number: _____

Current Address:

_____

_____

Permanent Address:

_____

_____

Residential Status: Owned / Rental

Monthly Rent (if applicable): _____

Details of Property:

- Movable (Vehicle/money/jewelry/livestock etc.)

_____

_____

_____

- Immovable (Agricultural land/shared property/house/flat/plot etc.)

_____

_____

_____

Family Details:

Sr#	Name	Age	Education	Occupation	Monthly Income (if applicable)	Relation with patient

Medical Evaluation (to be filled by referring/operating consultant)

Patient's Name: _____

Age: _____

CNIC #: _____

Consultant's Name: _____

Patient's Final Diagnosis: _____

Prognosis:

_____

_____

_____

Treatment Plan:

_____

_____

_____

_____

PMDC #: _____

Sign and Stamp: _____ **Date:** _____

Medical Evaluation Matrix

Full Name: _____

Case Number: _____

Referring Consultant: _____

Criteria	Weightage	Actual Score	Scoring Criteria
Age	30		(>65 = 10; 50-64 = 20; <50 = 30)
Treatment Type	20		(Medication = 10; Angioplasty = 20)
Chances of Recovery	30		(>Slight = 10; Moderate = 20; High = 30)
Urgency of Treatment	20		(>Not Urgent = 5; Urgent = 10; Very Urgent = 20)
Total	100		

Verification by Technical Review Committee

Name	Remarks	Signature
Dr. General Waqar Ahmed Consultant cardiologist		
Dr. Habib -Ur-Rehman Consultant Internal Medicine, Diabetologist & Endocrinologist		
Dr. Syed Muntazir Mehdi Director clinical support services		

Financial Evaluation Matrix

Full Name: _____

Case Number: _____

Referring Consultant: _____

Criteria	Weightage	Actual Score	Scoring Criteria
Residential Status	20		(Owned = 10; Rent = 20)
Monthly Income	20		(>100,000 = 5; 50,000 to 100,000 = 10; <50,000 = 20)
Number of Dependents	20		(<2 = 5; 3-5 = 10; >5 = 20)
Movable Property	20		(>300,000 = 5; 100,000 to 300,000 = 10; <100,000 = 20)
Immovable Property	20		(>500,000 = 5; 300,000 to 500,000 = 10; <300,000 = 20)
Total	100		

Verification by Financial Review Committee

Name	Remarks	Signature
Dr. Syed Muntazir Mehdi Director clinical support services		
Mr. Imran Nabi Executive Director		
Mr. Asif Saifullah Khan Chief Operating Officer		

Final Fund Approval

Full Name: _____

Case Number: _____

Referring Consultant: _____

Criteria	Weightage	Actual Score
Medical Evaluation Score	100	
Financial Evaluation Score	100	
Total	200	

Approval Matrix

- >180 = 90%
- 120-179 = 80% -89%
- 90 - 119 = 70% - 79%
- <90 = 60% - 69%

Verification by Approval Committee:

Name	Remarks	Signature
Mr. Asif Saifullah Khan Chief Operating Officer		
Mrs. Shireen Saifullah Chief Executive Officer		
Dr. Iqbal Saifullah Khan Chairman Saif Healthcare Ltd.		