|  |  |
| --- | --- |
|  | **EAGLES DIALYSIS CENTRE BHD**  **11, Jalan TP6, Taman Perindustrian UEP**  **47600 Subang Jaya, Selangor**  **Tel: 03-58853788 Fax: 03-58853766**  **Email: eaglesdialysis@gmail.com** |

**APPLICATION FOR TEMPORARY DIALYSIS TREATMENT**

Patient’s Name: ………………………………………………. Patient’s IC Number: ……………………………………

Patient’s Address: ……………………………………………………………………………………………………………………..

………………………………………………………………………………………………………………………

Patient’s Contact No: …………………………………………………. Email: ………………………………………………..

Patient’s Physician Name: …………………………………………… Physician Contact No: ……………………….

Centre Name: ……………………………………………….. Centre Tel No: ………………………………………….

Date(s) of Temporary HD Treatment Required: …………………………………………………………………………

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1) **MEDICAL DATA**

Etiology of ESRF: ……………………………………….. Date of first dialysis: ………………………………………..

Vascular Access: ……………………………………….. Other medical illness: ……………………………………….

2) **CURRENT DIALYSIS PRESCRIPTION**

Frequency and duration of dialysis: …………………………… Dry weight: ……………………………….

Type of dialysate: ………………………………………………………Size of dialyzer: ………………………….

Heparin regimen: ……………………………………………………… Blood flow: ………………………………..

3) **INVESTIGATIONS: DATE of tests: …………………………**

HbsAg: ………………………………………… AntiHBS: ……………………………………

AntiHCV: …………………………………….. HIV: ………………………………………….

4) **MEDICATION:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergy: NO YES (Specify): ………………………………………………………

…………………………………………………………… Date: ……………………………………….

Signature (SN)

Name: