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|  | **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: …………………………………………………………………………

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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:**

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

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

Signature (SN)

Name: