HOLIDAY DIALYSIS REQUEST
(to be completed by doctor or dialysis unit staff)

PERSONAL DETAILS:

Name:_____

Surname:_____

Date of birth:_____/_____/ _____

Home / postal address: _____

_____Tel:_____

Contactable relative:_____

Relationship: _____Tel _____

Arrival date on vacation:_____

Departure date: _____

Address while on vacation:_____

_____

Telephone number while on holiday:

_____

Name and address of your dialysis unit: _____

_____

Nephrologist: Dr _____

Tel. _____ Fax. _____

Cause of renal failure: _____

_____

Other medical problems:

On dialysis treatment since: _____/_____/ _____

_____

BLOOD TEST-SEROLOGY:

Hepatitis B (**HBSAg**): Neg./Pos._____ on _____/_____/ _____
Hepatitis B (**HBSAb**): Neg./Pos._____on _____/_____/ _____
Hepatitis B (**HBcAb**): Neg./Pos._____on _____/_____/ _____

Hepatitis C(**HCV**) o:Neg./Pos._____on ____/____/ ____
Hepatitis C **RNA-PCR HVC**: Neg./Pos._____on ____/____/ _____

HIV: Neg./Pos._____on ____/____/ _____

MRSA Swabs: Neg./Pos._____on ____/____/ _____

Hb: g/dl_____on _____/_____/ _____
Urea: mgs/dl_____on _____/_____/ _____
K: mEq/L: _____on _____/_____/ _____
Calcemia: mgs/dL: _____on _____/_____/ _____
Fosfatemia: mgs/dL: _____on _____/_____/ _____
ALT: UI _____ on _____/_____/ _____
AST: UI _____on _____/_____/ _____

Please include copies of lab latest Hepatitis B, C, HIV and MRSA blood test results.
Known allergies:

DIALYSIS DETAILS
Type: HD:_____HDF-ONLINE:_____

Dialysis duration: _____hours/ore

Frequency: _____ / week

Access type:
1) AV fistula /Graft_____Left _____Right _____

Needle size: _____gauge

2) Permanent catheter: _____

Heparin lock volume : A_____ml V _____ml

Dialyser: _____Dialysate flow: _____

Dialysate: K_____Ca_____Na_____

Low molecular weight heparin:

Generic name: _____dose/dosaggio:_____

Or

Sodium heparin:

Initial bolus: _____u; hourly: _____u or

continuously _____u/hour

Blood flow: _____ml/min Average intake on dialysis _____ml

Height:_____mt Weight:_____ kg

Dry weight _____kg Avg interdialytic gain _____kg

Blood Pressure: pre _____/_____post _____/_____

DIALYSIS PROBLEMS:

Hypotension _____Cramps _____Other:

Last results for dialysis adequacy:

Kt/V _____or URR _____ Date: _____/_____/_____

Current medication:(please include brand names and generic names of drugs)

EPO: dose _____frequency_____

Antihypertensives: _____

Phosphate binders:_____

Other:

History and Physicals-Special Requirements:

Payment method:

Cash:_____EHIC N°: _____

Expiry date:_____
(please include a cleare/well readable copy of the EHIC card both sides)

Pre payment by bank transfer: _____

Other relevant information e.g medical insurance details:

_____

Transplant List: _____

since:_____/_____/_____

_____ Date/: _____/_____/ _____

Signature
(Doctor / Sr in charge)

N.B. This form has to be filled in in every part, if not, receiving holiday nephrologist could deny the booking, being important information on the dialysis performed by trevelling patient missing.