FRESENIUS MEDICAL CARE

# HOLIDAY DIALYSIS REQUEST

(to be completed by doctor or dialysis unit staff)

**PERSONAL DETAILS:**

Title:
Mr./Mrs./Ms._____

Name:_____

Surname:_____

Date of birth:_____/_____/_____

Language:_____

Home / postal address: _____

_____

Tel:_____

Contactable relative: _____

Relationship: _____

Tel: _____

Arrival date on vacation:_____ Departure date: _____

Preferred treatment (dates & time): _____

Any attending person with the patient? His/her language? _____

Address while on vacation:_____

_____

**Please attach the Itinerary, if the patient stays at more than one place.*

Reservation name or number (if hotel): _____

Telephone number while on holiday: _____

**Please fill in detail, because this is especially important in case of any needs to contact the patient while on holiday.*

Name and address of your dialysis unit: _____

_____

Nephrologist: Dr. _____

Tel.:_____ Fax.: _____

Cause of renal failure:

_____

_____

On dialysis treatment since: _____/_____/_____



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Other medical problems:

**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 :

Nose: Neg./Pos._____ on __ /__ / __- Groin : Neg./Pos._____ on __ /__ / ___-

Throat: Neg./Pos. _____ on __ /__ / __- Any wounds: 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 (HbsAg, AntiHBS e AntiHBC), C, HIV and MRSA blood test results.



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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:_____

**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 _____/_____



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**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:



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**EHIC card:**

□ No

□ Yes

EHIC N°: _____

**Other relevant information e.g medical insurance details:**

_____

_____

_____

Transplant List: _____

since:_____/_____/_____

**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 travelling patient missing.**

**Doctor/ Sr. in charge**

Place, Date

_____

Signature

_____