APPLICATION FORM FOR HOLIDAY DIALYSIS

Please circle your answers or fill in the blanks where appropriate on the lines provided

PATIENT INFORMATION

Surname: Mr./Mrs. ---------- Intitials: ----------
First name(s): ---------- Date of birth: ----------

Home address: ----------

Telephone: ----------
E-mail address: ----------

HOLIDAY DIALYSIS INFORMATION

Desired period of treatment(s) From: ---------- Until: ----------
First and last holiday treatment dates Date of first treatment in HagaZiekenhuis: ----------
Date of last treatment in HagaZiekenhuis: ----------

Holiday address: ----------

Telephone: ----------

Contactperson during holiday period Name: ----------
(To be contacted in case of emergency) Relation: ----------
Telephone: ----------
Address: ----------

DIALYSIS INFORMATION

Requested (test) results should not be older than 4 weeks. Please provide test results.

Home dialysis center: ----------
Address: ----------

Telephone: ----------
Doctor: ----------

Serological test results:

	Test Results:	***Date of test result:***
Hep B antigen	Pos / Neg	
Hep B antibodies		
HCV (hepatitis C)	Pos / Neg	
HIV-test	Pos / Neg	

Microbiology test results:

M.R.S.A. screening (recent results):

*Please enclose labresults **less than one month** old!*
*Samples must be taken from: **Nose**, **Throat**, **Perineum (rectal)** and **the vascular acces point (AV Fistula/Graft** and/or **insertion wound of CVC (dialysis catheter))** and (if any) **damaged skin**)*

* MRSA-infection? Yes / No
* Results from: Nose, Throat, Perineum (rectal), shunt and/or CVC catheter Date: _____
* Has your dialysis centre had an M.R.S.A.-outbreak in the last 6 months? Yes / No

Other (possible) infections with pathogens/HRMO?

* Is there a suspicion or confirmation of other particular infections with pathogens the patient may have for which additional precautions/isolation requirements need to be applied to prevent transmission? (Does your dialysis treatment need to be in isolation/quarantine?)

O Yes — If so, what category of Transmission-Based Precaoutions/isolation is required?
- **O** Contact precautions
- **O** Droplet precautions
- **O** Airborne Precautions
- * Type of pathogen: _____

O No

Blood Chemistrey Panel:

Blood Test Results ***over the past month*** :

Creatinine	.....	umol/L
Bun (Urea)	.....	mmol/L
Sodium (Na+)	.....	mmol/L
Potassium (K+)	.....	mmol/L
Calcium (Ca2+)	.....	mmol/L
Phosphate	.....	mmol/L
Alkaline Phosphatase (ALP)	.....	U/l
Aspartate amino transferase (AST/ASAT)	.....	U/l
Alanine amino transferase (ALT/ALAT)	.....	U/l
Haemoglobulin	.....	mmol/L
Hematocrit	.....	Vol%
Blood Type	.....	pos/neg

Dialysis prescription:

Haemodialysis schedule: _____ x per week Dialysis duration: _____ hours

Vascular access:

O AV fistula/graft	Type and location:	_____
		_____
* Needle(s):	one / two	
O CVC central venous (dialysis) catheter	Type and location:	_____
		_____
* Heparin Lock:	_____ Volume lumen(s):	A:.....ml
* Lumen details:	single / double	V:.....ml

* If any: please give more details about any particular vascular acces issues/information:

_____

Blood flow: _____ ml/min
Dialysate concentrate: _____
Dialysate flow: _____ ml/min
Type of artificial kidney: Name: _____
Surface area: _____ m2
Prescriped type of and dosage of Anticoagulation
Priming during dialysis treatment: _____
Weight:
* Target weight _____ kg
* Adverage interdialytic weight gain between two dialysis: _____ kg
Bloodpressure:
* Average **Pre-dialysis** blood pressure _____/_____ mmHg
* Average **Post-dialysis** blood pressure _____/_____ mmHg
Urinary volume/24 hrs: _____ ml

Date of the first dialysis (HD/PD): _____

Medical history / Relevant diagnoses:

Cardiopulmonary resuscitation (CPR)? **O** Yes **O** No (DNACPR)
Notes: _____

Current transplant status: _____
Notes: _____

Recent changes/concerns/illness/problems:

Medication *DURING* dialysis:

Medication	Dosage	Prescribed moment (frequency) of administration

Other Medications:

Anticoagulants (oral) therapy?	**O** Yes **O** No	Which medication: ---------- Dosage: ---------- Anticoagulant activity measuring moment (blood test): ----------

Medication	Dosage	Prescribed moment (frequency) of administration

Dietary restrictions? **O** Yes **O** No

Notes: ----------

Allergies? **O** Yes **O** No

Notes: ----------