mesogeios DIALYSIS CENTERS

MEDICAL REPORT

(to be completed by the Nephrologists)

Name:_____

Surname:_____

Date of birth:_____

Nationality: _____

Name and address of the dialysis unit: _____

_____

Nephrologist: Dr _____

Tel. _____ Fax. _____

Cause of renal failure: _____

_____

Other medical problems:

Initiation on dialysis 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 _____ /_____ / _____
Calcium: mg/dL: _____ on _____ /_____ / _____
Fosphorus: mg/dL: _____on _____ /_____ / _____
SGOT: UI _____ on _____ /_____ / _____
SGPT: 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:_____

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 _____Muscle Cramps _____Angina _____

Nausea_____ Vomiting_____

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 medication:

History and Physicals-Special Requirements:

Signature and stamp:

(Nephrologist in charge)

(to be completed by the dialysis guest)

PERSONAL DETAILS OF THE DIALYSIS GUEST:

Name: _____Surname:_____

Passport Number: _____

Home / postal address: _____

_____ Tel:_____

E-mail: _____

Profession: _____

Insurance: _____

Insurance Serial No:_____

Name of the Hotel:_____

Travel Agency: _____

Arrival Date: _____ Departure Date:_____

Arrival time: _____ Flight Number: _____

Contact person in case of emergency: _____

Relationship: _____Tel _____

Telephone number while on holiday: _____

Date/: _____ /_____ / _____