

Part A

To be completed by the Patient

CENTRO EMODIALISI GARDA
Via S. Caterina, 94/d
I - 38062 ARCO / LAKE GARDA
Tel. 0039 0464 531153
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APPLICATION FORM

Surname _____ First name _____

Date of birth _____ Address _____

Town _____ Country _____

Post Code _____ Tel. _____ E-mail _____

Usual Dialysis Centre _____

Town _____ Road _____ Country _____

Responsible Doctor _____

Tel. n° of Doctor Responsible and of Dialysis Centre _____

HBs-Ag pos. neg. HCV pos. neg. HIV pos. neg.

Handicap: yes no

What? _____

I wish to undergo holiday dialysis at the Garda dialysis Centre

from _____ (1st day of dialysis) to _____ (last day of dialysis), or

from _____ (1st day of dialysis) to _____ (last day of dialysis)

Address while on holiday _____

Telephone number while on holiday _____

Should the application be accepted by the centre, this will serve as definite confirmation on my part.

Inclosed I send you my EHIC - European Health Insurance Card.

Date _____

Signature _____

Part B/1

To be checked and signed by own Doctor

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Holiday dialysis at the Garda Dialysis Centre

from _____ (1st day of dialysis) to _____ (last day of dialysis)

Surname _____ First name _____

Date of birth _____ Address _____

Town _____ Country _____

DIALYSIS DETAILS

On dialysis treatment since _____

Dialysis currently carried out at home in a Clinic

N° of Dialysis per Week _____ Duration of Dialysis (Hours) _____

Residual renal activity: yes no ml/24h _____

Access type: AV fistula / Graft left right One needle Two needles

Schribner –Shunt left right

CVC - Permanent catheter Tesio monolumen bilumen

Dialysis type: Bicarbonate Online Dialysis HDF Other _____

Type of Machine _____ Dialyser _____ Dialysate _____

Dry weight _____ kg Avg Weight Gain _____ kg

Max hourly decrease of weight _____ g Blood flow _____ ml/min

Dialysis bath: Na⁺..... K⁺..... Ca⁺⁺..... Mg⁺⁺.....Glucose HCO₃⁻

Heparin: Sodium Low molecular weight: name: _____ dose: _____

initial bolus _____ ui. ; continuously _____ ui/hour

BP : pre _____ post _____

Dialysis problems:

Hypertension: yes no Hypotension: yes no

Cramps: _____ Other: _____

Diabete ID NID Dicumarol yes no Other:

Health of the patient: good discret bad

Is the patient in conditons, that he could dialyse in a **Dialyse Unit low care**? yes no

Handycap: yes no

What? _____



Part B/2

MARKERS ()** date _____

HBs-Ag pos. neg. HCV pos. neg. HIV pos. neg.

BLOOD RESULTS ()** date _____

Hb: Kreat: Na+:

Ery:..... BUN: K+:

Ht: Leuko: Ca++:

P: HCO3-

AST: ALT: Bloodgroup:

(**) Please include copies of latest Bloodresults (not older as 30 days)

Important medical history:

Renal diagnosis disease:

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

Medication at the end of the dialysis:

Possible clinical notes / problems / allergy:

Date _____

Stamp

Signature
(Doctor / Sr in charge)