APPLICATION FORM FOR HOLIDAY DIALYSIS

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PATIENT INFORMATION

Name, Chr.Name: *Date of birth:* *Home address:* *Telephone:* *Email address:*	
Name and address of your dialysiscentre: *Physician:* *Telephone:* *Mailaddress:*	
Insurance: *Number:* *Identifaction Card:* *Number:*	
Holiday adress: *Contact:* *Relation:* *Address:* *Telephone:*	

HOLIDAY INFORMATION

Desired period of treatment: *Date first treatment:* *Date last treatment:*	

DIALYSIS PLAN

Times per week: *Hours per treatment:*	
Dialyzer: *Vasculair access:* *Single- or doubleneedle treatment:*	
Bloode type:	
Kind of anticoagulantia: *Prime: (I.U.)* *2nd shot (I.U.)*	

Continue: (I.U.)	
Concentrate (Kalium, Calcium): *Temp dialysaat:* *Bicarbinaat:* *Blood flow:* *Dialysaatflow:*	

DIALYSIS INFORMATION	
Dialysis since:	
Present problems:	
Diuresis:	
Diet:	
Dry weight: *Weight gain inbetween dialysis sessions:*	
BP before dialysis: *BP after dialysis:*	- -

To be completed by the attending physician

Name physician	
Diagnosis	
Medical History	*Send as an attachment*
CPR Policy	
HIV	**Testresults** **Date:** Please send testresults as an attachment
HBsAg < as 1 month befor your first dialysis in our centre	**Testresults** **Date:** Please send testresults as an attachment
Allergies	**Yes;** **No**

Send as an attachment:

- **Medication list**
- **Recent laboratory results**
- **Medical letter Nephrologist with Medical history**
- **Copy of your Identification Card**
- **Copy of your insurance card, both sides.**