

Request for patient information: Holiday patients

PATIENT DETAILS

Full name:	Date of birth:
Home address:	Country of residence:
Tel:	E-mail:
Holiday address:	Holiday tel (if other than above):

HEALTH INSURANCE

Social security/identification (NHS) number:
EHIC/GHIC (include copy of card):
Private health insurance:
Other:

NEXT OF KIN

Full name:	Tel:
Home address:	

REFERRING UNIT

Name of unit:	Tel/Fax:	
Address:		
Contact name:	Tel:	
Responsible Physician:	E-mail:	Tel:

DATES OF HOLIDAY DIALYSIS

First session:	Last session:	No. of sessions
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DIALYSIS INFORMATION

Dialysis modality:

HD: HDF –pre:

HDF-post: Other, please specify:

Days of week of patient's dialysis and duration:

Dry weight (kg):

Dialysate prescription:

QB (ml/min): QD: Bicarbonate: Conductivity: Sodium:

Dialysate: Dialysate temp: K: Calcium: Glucose:

Vascular access details (eg type, site & needle size):

Condition of vascular access (eg good, fair, poor):

Average inter-dialytic weight gains (kg):

Average blood pressure:

Pre-dialysis: Post dialysis:

RECENT LABORATORY RESULTS:

Last HB:

Hepatitis B status: Date:

Hepatitis C status: Date:

HIV status: Date:

MRSA (nose, groin, wound) status: Date:

VRE, CPE & ESBL (rectum) status: Date:

Please note: Test results should not be more than 30 days old counted from first holiday treatment in our clinic.
Original laboratory results to accompany this form.

d.HOLIDAY dialysis

MEDICAL HISTORY

First haemodialysis date:

Initial diagnosis:

Other major illnesses (Please send accompanying letter if necessary):

Allergies:

Intradialytic medications (Heparin, EPO, iv Iron, vitamin D or other) and dosage:

Heparin dose and frequency (initial/continuous):

Erythropoietin dose and frequency (Please note: The patient should bring all medications needed during dialysis):

Other medications and dosage (List of medications to accompany this form):

Other relevant information/problems on dialysis/any special requirements:

d.HOLIDAY dialysis

COVID STATUS

Vaccination status:

Dates of all doses given:

Please note: Negative Rapid Antigen test or a PCR test must be carried out 72 hours prior to arrival at our clinics' Diaverum self-assessment for COVID-19 before admission' to accompany this form.

Other major illnesses (Please send accompanying letter if necessary):

Signed:

Signed:

Authorising doctor's name & signature: