

# Request for patient information: Holiday patients

## PATIENT DETAILS

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Full name:

Date of birth:

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Home address:

Country of residence:

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Tel:

E-mail:

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Holiday address:

Holiday tel (if other than above):

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## HEALTH INSURANCE

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Social security/identification (NHS) number:

EHIC/GHIC (include copy of card)

Private health insurance

Other:

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## NEXT OF KIN

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Full name:

Tel:

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Home address:

## REFERRING UNIT

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Name of unit:

Tel/Fax:

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Address:

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Contact name:

Tel:

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Responsible Physician:

E-mail:

Tel:

## DATES OF HOLIDAY DIALYSIS

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First session:

Last session:

No. of sessions

# Request for patient information: Holiday patients

## DIALYSIS INFORMATION

Dialysis modality:

HD      HDF -pre      HDF-post      Other, please specify:

Days of week of patient's dialysis and duration:

Dry weight (kg):

Length (cm):

Dialysate prescription:

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

Dialysate:      Dialysate temp:      K:      Calcium:      Glucose:

Dialyser type & size:

Access details (eg type, site & needle size):

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

Average inter-dialytic weight gains (kg):

Average blood pressure:

Pre-dialysis:

Post dialysis:

## RECENT LABORATORY RESULTS:

Last HB:      Date:

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

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First haemodialysis date:

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Initial diagnosis:

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

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Allergies:

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

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Anticoagulant dose and frequency (initial/continuous):

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Erythropoietin dose and frequency:

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Please note: The patient should bring all medications needed during dialysis

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Other medications and dosage:

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List of medications to accompany this form

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

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# d.HOLIDAY dialysis

## TRANSPLANTATION STATUS

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Active on transplantation list (Yes/No):

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Date of acceptance on transplantation list:

## COVID STATUS

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Vaccination status and dates of last dose given:

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Signed:

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Authorising doctor's name & signature: