

PATIENT INFORMATION SHEET FOR TRANSIENT HAEMODIALYSIS

IDENTIFICATION DATA

Patient's Name: _____ Date of Birth: _____ Sex: _____
Home Address: _____
Home Phone No.: _____ Occupation: _____
Next of Kin /Phone No.: _____
Dialysis Date Requested: _____
Arrival Date: _____ ~ Departure Date: _____
Visiting Hotel Name: _____
Visiting Phone No.: _____

GENERAL TREATMENT INFORMATION

Primary Renal Disease Diagnosis: _____

Complications:

#1
#2
#3
#4
#5

Infectious Disease: _____ Allergy: _____
Blood Type: _____ Rh () HbsAg () Anti-HCV Ab () RPR () HIV ()
Medications (oral): _____

HAEMODIALYSIS DATA

Initial Dialysis Date: (___ / ___ / ___) Last Dialysis Date: (___ / ___ / ___)
Dialysis per Week: ___ times Hours per Treatment: ___ hrs.
Ideal Dry Weight: ___ kg Usual Weight Gains: ___ kg
Blood Flow Rate: ___ ml/min Dialysate Flow Rate: ___ ml/min
Venous Outlet Pressure: ___ mmHg UFR/TMP: ___ ml/hr.
Temperature: _____
Dialyzer Brand: _____ Model: _____
Surface Area: ___ m sq. Membrane: _____
Dialysate Bicarbonate(HCO3): ___ mEq/L Potassium(K): ___ mEq/L
Sodium(Na): ___ mEq/L Calcium(Ca): ___ mEq/L Dextrose(Glu): ___ g/L

Heparinization Initial Dose: _____ u Hourly Dose: _____ u × hrs.
Stop Time: _____ min before finish dialysis (Loading Dose: _____ u)
Vascular Access Type: _____ Needle Size: _____ Local Anaesthetic: _____
AverageSupineBP(right lower extremity); _____
Treatment during dialysis; (i.v) _____

5EXAMINATIONS

Laboratory Data; (____ / ____ / ____)

Hb_____g/dl Ht_____% BUN_____mg/dl Cre_____mg/dl K_____mEq/l
Ca_____mg/dl P_____mg/dl TP_____g/dl Alb_____g/dl UA_____mg/dl
Glu_____mg/dl HbA1c_____% CRP_____mg/dl
GOT(AST)____iu/l GPT(ALT)____iu/l

Chest X-ray; (_____) CTR=_____

ECG; (_____)

Physical examination; (____ / ____ / ____)

NOTE

Date: _____

Hospital name _____

Tel. _____ Fax. _____

Dr signature _____