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: _____

SurfaceArea: _____ 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_____