Call Center int. patients
+30 22410 45045
info@euromedica-rhodes.gr
dialysis@euromedica-rhodes.gr
Koskinou, Municipality of Kallithea,
P.O.box 22113, 85105, Rhodes

EUROMEDICA
Dialysis Centre

APPLICATION FORM FOR HOLIDAY DIALYSIS 2018

Name		Date of Birth	...../...../.....
Home Address		Postal Code	
Country		E-mail	
Telephone Nr		Mobile Nr	
Date of Arrival	...../...../.....		
Date of the first Dialysis in Euromedica Rhodes	...../...../.....		
Date of the last Dialysis in Euromedica Rhodes	...../...../.....		
Contact person in case of emergency			
Phone Nr. of contact person			
E-mail of contact person			
Name of your Dialysis Center			
Address		City: Country: Postal Code:	
Nephrologists		Telephone Nr	

Payment Method

Cash ☐

EHIC Nr		Expiry Date	...../...../.....

(please include a copy of both sides of the EHIC card)

Other relevant information

Travel Insurance		Policy Nr	
Transplant List Since	...../...../.....		

Notes / Comments:

Signature of Patient

X

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EUROMEDICA
Dialysis Centre

To be completed by a Doctor

Type of dialysis treatment you are currently receiving

☐ Haemodialysis ☐ Hemodiafiltration ☐ On-Line Hemodiafiltrat

Type of dialysis machine:..... Type of dialyzer:.....

Dialysis Information

Blood group:..... Rhesus factor:.....

Australia Antigen Test	☐ positive	☐ negative	dated ...../...../.....
HCV (Hepatitis C-virus)	☐ positive	☐ negative	dated ...../...../.....
HIV-test	☐ positive	☐ negative	dated ...../...../.....
MRSA-infection	☐ positive	☐ negative	dated ...../...../.....

Diagnosis and history: PLEASE ENCLOSE LETTER

Recent problems:.....

.....

The patient has been treated with dialysis since: ...../...../.....

Haemodialysis schedule: Times per week..... Duration.....hours.

Vascular access:.....left / right; one / two needle(s)

Needle size: .....Temperature:..... Buttonhole: yes / no

Blood pressure:..... mmHg (ante dialysis) /.....mmHg (post dialysis)

Ideal weight:..... kg Average ultrafiltration need:.....Urinary volume/24 hrs.: .....ml

Blood flow:.....Dialysis Fluid flow:.....

Erythropoetin: YES / NO Brand:..... Dose:.....IV / SC / IP

Composition of dialysate: .....

Heparinization: Fraxiparine.....ml.

Present medication: please enclose medication list not older than 3 month
Laboratory results: please enclose laboratory results not older than 3 month

Diet:.....Allergies:.....

History the last six months:

Unstable angina pectoris	yes / no
Heart problems	yes / no
Hyperkaliaemia	yes / no
Shunt problems	yes / no
Serious infections	yes / no
Surgery	yes / no
Haemodynamic instability during haemodialysis sessions	yes / no

Other complications yes / no

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.....

Mobility

The patient depends on a wheel chair / has trouble walking or please specify any physicals requirements

Signature of nephrologist in charge

X