

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:

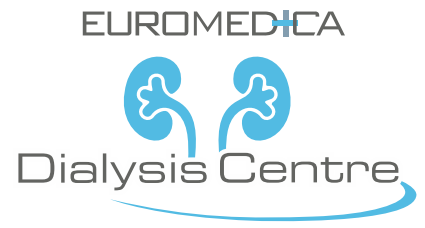
[]

Signature of Patient

X []

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

Signature of nephrologist in charge
X