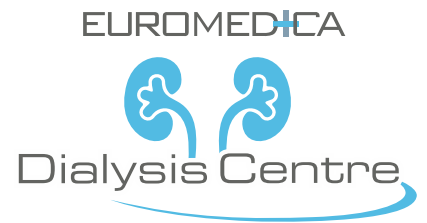


Call Center int. patients

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



APPLICATION FORM FOR HOLIDAY DIALYSIS 2018

Name	<input type="text"/>	Date of Birth	<input type="text" value="...../...../....."/>
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Home Address	<input type="text"/>	Postal Code	<input type="text"/>
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Country	<input type="text"/>	E-mail	<input type="text"/>
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Telephone Nr	<input type="text"/>	Mobile Nr	<input type="text"/>
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Date of Arrival	<input type="text" value="...../...../....."/>
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Date of the first Dialysis in Euromedica Rhodes	<input type="text" value="...../...../....."/>
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Date of the last Dialysis in Euromedica Rhodes	<input type="text" value="...../...../....."/>
--	--

Contact person in case of emergency	<input type="text"/>
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Phone Nr. of contact person	<input type="text"/>
-----------------------------	----------------------

E-mail of contact person	<input type="text"/>
--------------------------	----------------------

Name of your Dialysis Center	<input type="text"/>
------------------------------	----------------------

Address	<input type="text"/>	City:	<input type="text"/>	Country:	<input type="text"/>
		Postal Code:	<input type="text"/>		

Nephrologists	<input type="text"/>	Telephone Nr	<input type="text"/>
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Payment Method

Cash

EHIC Nr	<input type="text"/>	Expiry Date	<input type="text" value="...../...../....."/>
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(please include a copy of both sides of the EHIC card)

Other relevant information

Travel Insurance	<input type="text"/>	Policy Nr	<input type="text"/>
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Transplant List Since	<input type="text" value="...../...../....."/>
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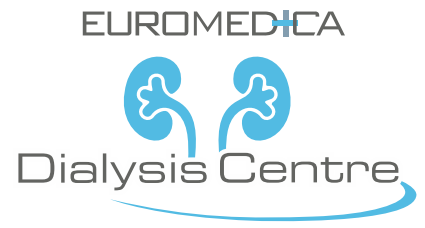
Notes / Comments:

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:

Table with 2 columns: History the last six months, yes / no. Rows include Unstable angina pectoris, Heart problems, Hyperkaliaemia, Shunt problems, Serious infections, Surgery, Haemodynamic instability during haemodialysis sessions.

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