



Haemodialysis Medical Summary Sheet (For Tourist)

Identification Data			
Patient's Name (Mr./Mrs./Ms./Miss) _____			
Date of birth: _____ (dd/mm/yyyy)	Age: _____	Sex: M / F	
Home Address: 			
Home Phone no.:		Mobile:	
E-mail:		Fax:	
Address in Hong Kong: 			
Phone no. in Hong Kong:			
<u>Emergency Contact</u>			
Next of Kin:	Relationship:	Phone number:	
General Medical information:			
Diagnosis:			
Underlying Diseases:			
Allergies	<input type="checkbox"/> Yes, Please specify:	<input type="checkbox"/> No	<input type="checkbox"/> Not Known
Current Medications: 			
Dialysis Treatment Dates Requested			
No. of Treatment sessions in Hong Kong:	Treatment Schedule:		
	<input type="checkbox"/> Mon/Wed/Fri	AM (starts before 8:00 am) / PM (starts before 2:00 pm)	
	<input type="checkbox"/> Tue/Thur/Sat	AM (starts before 8:00 am) / PM (starts before 2:00 pm)	
Arrival Date: _____ (dd/mm/yyyy)	Departure Date: _____ (dd/mm/yyyy)		
First Treatment: _____ (dd/mm/yyyy)	Last Treatment: _____ (dd/mm/yyyy)		



Haemodialysis Medical Summary Sheet (For Tourist)

Specific Haemodialysis Data:		
Date Dialysis Initiated: _____	No. of Sessions per Week : _____	Duration of Dialysis : _____ hrs/session
Type of Dialyzer: _____	Surface Area: _____	
Dialysis Prescription: <input type="checkbox"/> HD <input type="checkbox"/> On-line HDF	Blood Flow Rate (ml/min): _____	
Vascular Access: Fistula / Goretex graft / Catheter Site _____	Type of Needle: _____	
Average BP Pre-dialysis /	Average BP Post-dialysis: /	
Dry Weight (kg) _____	Average Interdialytic weight gain: _____	
Dialysate: Bicarbonate _____ Na _____		Temperature: _____
K: _____ Ca: _____	Dialysate Flow Rate Auto flow / _____ (ml/min)	
ANTICOAGULATION Heparin / LMWH / Others _____		
Initial Dose _____	Hourly Dose _____	Heparin stopped _____ mins before end
Special Dialysis Requirements/ Complications 		
Valid Laboratory Data (within 4 weeks of the holiday dialysis dates) The following lab tests MUST BE done <i>within 4 weeks prior to visitor's requested date</i> and MUST BE emailed / faxed to our hospital before accepting the booking. Lab test items: ✓ HIV ✓ HBsAg ✓ HBsAb ✓ HCV-Ab ✓ Hepatitis B core Total Antibody <i>(If HBsAb Negative & Hepatitis B core Total Antibody positive, please check HBV DNA Quantitative PCR)</i>		
This form must be accompanied by copies of the following information for confirmation of booking and appointment date(s). 1. Valid Laboratory Report 2. Medical Letter from referring Nephrologist / Doctor 3. Current medication chart (Signed by a medical officer) 4. Three recent dialysis treatments sheets.		
Please note: Please send the above requested information to us. We are not able to confirm the treatment without them. Please send or fax this form with appropriate documents to RDC@hksh-hospital.com / (852) 2892 7524.		