



養和醫院

Hong Kong Sanatorium & Hospital

Renal Dialysis Centre

**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:			
Emergency Contact			
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)	



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: _____
Ca: <input type="checkbox"/> 1.25mmol/L <input type="checkbox"/> 1.75mmol/L <input type="checkbox"/> 1.5mmol/L with 5mmol/L Glucose		Dialysate Flow Rate Auto flow / _____ (ml/min)
ANTICOAGULATION		
Heparin / LMWH / Others _____		
Initial Dose _____	Hourly Dose _____	Heparin stopped _____ mins before end
Special Dialysis Requirements/ Complications		
<p>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: <input checked="" type="checkbox"/> HIV <input checked="" type="checkbox"/> HBsAg <input checked="" type="checkbox"/> HBsAb <input checked="" type="checkbox"/> HCV-Ab <input checked="" type="checkbox"/> Hepatitis B core Total Antibody <i>(If HBsAb Negative & Hepatitis B core Total Antibody positive, please check HBV DNA Quantitative PCR)</i></p>		
<p>This form must be accompanied by copies of the following information for confirmation of booking and appointment date(s).</p> <ol style="list-style-type: none"> Valid Laboratory Report Medical Letter from referring Nephrologist / Doctor Current medication chart (Signed by a medical officer) Three recent dialysis treatments sheets. 		
<p>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.com / (852) 2892 7524.</p>		