腎科透析中心
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	☐ Yes, Please specify:	☐ No	☐ Not Known
Current Medications:			

Dialysis Treatment Dates Requested		
No. of Treatment sessions in Hong Kong:	Treatment Schedule:	
	☐ Mon/Wed/Fri	AM (starts before 8:00 am) / PM (starts before 2:00 pm)
	☐ 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)	

16/F, Li Shu Pui Block, 2 Village Road,
Happy Valley, Hong Kong
Tel: (852)2835 8926 / Fax: (852)2892 7524
E-mail: RDC@hksh-hospital.com

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Specific Haemodialysis Data:		
Date Dialysis Initiated:_____	No. of Sessions per Week :_____	Duration of Dialysis : _____ hrs/session
Type of Dialyzer:	Surface Area:	
Dialysis Prescription: ☐ HD ☐ 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_____ K: _____ Ca: _____	Temperature:_____ 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 *within 4 weeks prior to visitor's requested date* 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*
  (If HBsAb Negative & Hepatitis B core Total Antibody positive, please check HBV DNA Quantitative PCR)

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.

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