

Home dialysis center

City Phone E-mail

Responsible doctor

MEDICAL DIALYSIS PROTOCOL

to be completed by the home dialysis center doctor

First name and Surname Date of birth

Address City

Phone E-mail

Diagnosis

Allergies

On dialysis treatment since Patient's general condition: good discreet poor

Patient with special needs: NO YES description Handicapped: NO YES

Dialysis type: HD (bicarbonate) HDF Dialysis duration: 4 hours

Dialysis days: Monday, Wednesday, Friday Tuesday, Thursday, Saturday Shift 1 Shift 2

Access type: AV fistula Catheter Blood flow (ml/min) Dry weight

Type of machine

Solution Na+ K+ Ca++

Mg++ Glucose HCO₃⁻

Dialyser (type) Solution flow Solution temperature

Heparinisation

Medications and dosage

Markers: (not older than 30 days) – date of test results

Markers: (not older than 30 days) HBs-Ag; Anti HBs; Anti HCV; Anti HIV Pozitivan Negativan

Lab test results: Hb Htc Kreatinin Na+ K+ Ca++

P AST ALT Glucose at the arrival, submit a copy of the test

Consent: The patient is referred for hemodialysis treatment at the **Polyclinic REDIAL** – Center for hemodialysis in 51513 Omišalj, Poje 1, on the island of Krk, Croatia, Phone, fax: 00 385 (0)51 841- 896; E-mail: redial.hemodialysis.krk@gmail.com

Last dialysis carried out on (date)

Date Signature _____

Stamp: