HEMODIALYSIS REFERRAL FORM

Hospital name

Street addres

Phone: **Fax:**

Patient Information

Patient Name		Birth Date		Sex		Blood Type	
Home Adress				Tel			
Attending M.D.				Tel			
Initial Dialysis Date							
Length of Stay Form							
Dates Requested for Dialysis							
Contact in Japan							

Dialysis Information

Hours of Treatment						
Dialyzer Type		Sterilization Method			Surface Area	m^2
Dialysate Concentration	Na	K	Cl	Ca	Mg	mEq/L
	HCO_3^- mmol/L	Glucose mg/dL				
Delivery System		Dialysate Flow			mL/min	
Blood Flow Rate	mL/min	Average Venous Resistance			mmHg	
Access		Size	G			
Heparinization Initial Dose	U	Hourly Dose			U/hour	
Dry weight	kg	Average Weight Gain			kg	
Average Blood Pressure	Pre / mmHg	Post / mmHg				
Possible Complications During Dialysis	Hypotension?	**Yes / No**	Hypertension	**Yes / No**	Arrythmia?	**Yes / No**
	Cramps?	**Yes / No**	Others?			

Specification Laboratory Data

Date		HBAg	( )	HCVAb	( )	HIV	( )
BUN	mg/dL	Creat	mg/dL	UA	mg/dL	TP	g/dL
Na	mEq/L	K	mEq/L	Cl	mEq/L		
Ca	mg/dL	PO^4	mg/dL				
GOT	U/L	GPT	U/L				
WBC	/μL	RBC	/μL	Hct	%		

ECG :

Chest X-P :

Medications list
