Application Form for Transient Dialysis (For Medical Institution)

Date: _____ Hospital or Facility Name: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Physician in charge: _____ Signature: _____

Person in contact for dialysis: _____

Patient Name	
Date of Birth (mm/dd/yyyy)	(Age Sex)
Request date for dialysis	
Primary disease	
Date of first dialysis?	
Dialysis Prescription	
Dialysis frequency	(Mon/Tues/Wed/Thurs/Fri/Sat)___hours___mins per dialysis
Type of Dialyzer	
Dialysate Rx:	K+_____ CA++_____ Dextrose_____ Sodium_____ Bicarb_____ Acetate_____
Quantity of flow	Quantity of blood flow ml/min
	Quantity of blood flow in dialysis ml/min
Anticoagulant	
Vascular access	Right and Left AV fistula/ AV graft/ Catheter
Puncture needle	Arterial side Venous side
Dry Weight	Kg/ Cardiothoracic ratio(CTR) %
	(Date of imaging weight kg)
Medication to be injected during dialysis	
Medication to be taken during dialysis	
Regular prescription	
Allergy and contraindicated drug	
Infectious disease	HBs Antigen ( ) HBs Antibody ( ) HCV ( ) HIV ( ) TPHA ( )
Others	

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