

## 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?	
<b>Dialysis Prescription</b>	
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 <span style="float: right;">ml/min</span>
	Quantity of blood flow in dialysis <span style="float: right;">ml/min</span>
Anticoagulant	
Vascular access	Right and Left AV fistula/ AV graft/ Catheter
Puncture needle	Arterial side <span style="float: right;">Venous side</span>
Dry Weight	Kg/ Cardiothoracic ratio(CTR) <span style="float: right;">%</span>
	(Date of imaging <span style="float: right;">weight <span style="float: right;">kg</span></span> )
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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English-language sentences shall conform to their Japanese-language counterparts.

Any legal responsibility involved shall be governed and construed based on Japanese-language sentences.