# Application Form for Transient Dialysis (For Patient)

Please make the reservation at least 2 weeks before the request date. We cannot accept reservation for the next day.

□Patient Name: _____

□Date of Birth (mm/dd/yyyy): _____ (Age Sex )

□E-mail address: _____

□Telephone number: _____

□Have you ever had a dialysis at St. Luke's International Hospital? YES • NO

If "Yes," please provide your patient registration card number: _____

□What day do you usually have your dialysis?

Monday • Wednesday • Friday Tuesday • Thursday • Saturday

Others ( )

□When was your last dialysis? _____ month _____ date _____ day

□Where do you usually have your dialysis? Hospital(name) • Facility(name) • Home

_____

□Address of the hospital/facility where you have your dialysis.

_____

□Contact number of the hospital or facility where you have your dialysis?

Telephone number: _____ Fax number: _____

□Type of blood purification therapy: HD • HDF

*We might not be able to offer HDF depending on the availability of bed and dialysis machine.

□Time of dialysis: _____hour/s

*Please note that it is difficult to perform dialysis for more than 4 hours.

□Infectious Disease: *There is a specific bed for patients who have infectious disease.

Hepatitis B: YES • NO

Hepatitis C: YES • NO

Others: _____

□Request Date of Dialysis: _____ month _____ date(/s)

□Preferred Time for Dialysis: _____ o'clock

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