

**CENTRE HOSPITALIER
DU NORD**

120, Avenue Salentiny
L-9080 ETTTELBRUCK



DIALYSE

Téléphone: 8166-5760

Fax: 8166-5769

Dr. Bauler Marcel / Dr. Braconnier Philippe

Dr. Schmit Eric / Dr. Weis Daniel

Dr. Regenauer Ron

Dear Mr.,
Dear Mrs.,

Thank you for your request for dialysis in our centre during the period

from _____ until _____.

We kindly ask you to return the enclosed document completed by your doctor and including blood test results as well as MRSA, MDRO, Hepatitis B/C and HIV screenings (all not older than 1 month) and a current medical report.

Please note that we only can confirm your inquiry after receiving these documents.

In order to confirm the date and the hour of your first dialysis in our center, please contact us 2 weeks before your departure.

Please do not forget your EHIC and your ID Card for registration before your first dialysis here.

Thank you for your cooperation.

Name of the nurse

Questionnaire

Name _____ First name _____

Date of birth _____ Insurance number _____

E-Mail _____

Private address _____

Phone _____ Fax _____

Holiday address _____

Phone _____ Fax _____

Address of your dialysis centre _____

Phone _____ Fax _____

Date of first dialysis _____

Nephropathy _____ Residual diuresis (ml) _____

Associated diseases _____

Allergies _____

Shunt: ☐ yes ☐ no ☐ Gore-Tex

☐ left ☐ right ☐ localization _____

☐ Unipunction ☐ Bipunction ☐ blood flow _____ ml/min

☐ Needle size (Gauge and length) _____

Catheter: ☐ left ☐ right ☐ localization: _____

☐ Single lumen ☐ double lumen

☐ Lock: (Active substance) _____ / A = _____ ml V = _____ ml.

Dialysis time (h) _____

☐ morning

Dialysis days in your centre _____ ☐ afternoon

Questionnaire

Last dialysis in your centre _____

Next dialysis in your centre _____

Membrane _____ Surface _____ CUF _____

Dialysate: Na (mval/l) _____ K+ (mval/l) _____

Ca (mval/l) _____ Gluc. (mg %) _____

Anticoagulation:

☐ Heparinization: charge dose _____ Contin. dose _____ U.I./h

☐ low-molecular-weight heparin: _____ mg

☐ others: _____

Complications during the dialysis

Weight _____ Gain of weight _____

RR before dialysis _____ RR after dialysis _____

EKG _____ Transplant waiting list ☐ yes ☐ no

Blood group _____

Medication
(during dialysis) _____

Medication
(at home) _____

Questionnaire

Please enclose to this questionnaire:

- Laboratory results
- Serology Hep. B/C and HIV (not older than 1 month)
- Screening MRSA (nose, mouth, inguinal) (not older than 1 month)
- Screening MDRO (rectal) (not older than 1 month)
- Current medical report
- Current list of medication
- Blood group
- ID-Card copy
- EHIC copy
- form S2 (check with your health insurance company)