CHdN
CENTRE HOSPITALIER DU NORD

Service de Dialyse
Tél.: +352 8166-5760 / Fax: +352 8166-5769
Dr. Bauler Marcel / Dr. Boulmerka Hocine /
Dr. Henriquez Daniel / Dr. Weis Daniel /
Dr. Braconnier Philippe

Dear Sir,

Dear Madam,

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

from _____until _____

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

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

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

Please do not forget your EHIC and your ID Card.

We thank you for your cooperation.

_____

Name / signature of the nurse

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L-9002 Ettelbruck

Téléphone (+352) 8166-1
Fax (+352) 8166-3080
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Questionnaire

Name _____ First name _____

Date of birth _____ Insurance number _____

Email _____

Private address _____

Phone _____ Fax _____

Holiday address _____

Phone _____ Fax _____

Address of your dialysis center _____

Phone _____ Fax _____

Date of the first dialysis _____

Nephropathy _____ Residual diuresis (ml) _____

Associated diseases _____

_____

Allergies _____

_____

Shunt ☐ yes ☐ no ☐ Gore-Tex

☐ left ☐ right ☐ localization _____

☐ Unipuncture ☐ Bipuncture ☐ 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) _____

Dialysis days in your center _____ ☐ morning ☐ afternoon

Last dialysis in your center _____

Next dialysis in your center _____

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:

_____

_____

_____

Please enclose the following documents to this questionnaire :

- Laboratory results
- Serology Hep. B/C und 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