CENTRE HOSPITALIER
DU NORD
120, Avenue Salentiny
L-9002 Ettelbruck

Dialysis Center
Tel.: 8166-5760
Fax.: 8166-5769
Dr. Bauler Marcel / Dr. Braconnier Philippe
Dr. Schmit Eric / Dr. Weis Daniel

Dear Mr. …….. ,
Dear Mrs. ……..,

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 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 center _____

Phone _____ Fax _____

Date of 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) _____

☐ morning

Dialysis days in your center _____ ☐ afternoon

Questionnaire

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) _____

_____

_____

_____

_____

_____

Questionnaire

Please enclose 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
- form S2 (check with your health insurance company)