Azienda USL Toscana nord ovest
Servizio Sanitario della Toscana

Treatment dates Requested: FROM..... TO.....

Patient information

Name _____ _____DOB___/___/___

Home address: _____

Contact numbers : _____

Address in Italy:_____

Contact number in Italy (if available):_____

Emergency Contact Number and Name:_____

Insurance number card: _____

Reffering Home Dialysis Unit:

Home Dialysis Unit: _____

Referring Doctor: _____

Emergency Contact number and email: _____

Dialysis Information:

Access Type and Location:_____

Dialyzer:_____

Dialysis frequency_____/week. Lenght of treatment_____

Dialysate: Na_____ K_____ Ca_____ Blood flow_____

Needle size _____

Dry Weight _____ Kg_____

Heparinization: _____

If Catheter access, dwell type and amount: Arterial port_____Vein port_____

Average PRE treatment BP_____Post treatment BP_____ Average weight gain beetween dialysis_____

Intradialytic Problems/comments: _____

Patient Medical Information:

Primary diagnosis_____

Secondary diagnosis_____

Comorbid conditions_____

Date of initial dialysis_____

Is the patient a transplant candidate?_____

Diabetic? NO____ YES_____ Type?_____ Insulin dependent?_____

Hepatitis B : HbsAg _____ HBSAb _____ HCV Ab_____ HIV_____ (max last three months)

DIALYSIS UNIT VISITING PATIENT FORM

Patient Name_____

Home medications:

_____
_____
_____
_____

Intradialytic medications:

_____
_____
_____
_____

REQUIRED INFORMATION:

1. List of home medications with dosage/frequency
2. European Insurance card all other applicable insurance cards
3. Copies of recent monthly labs
4. Copies of most current EKG and CHEST X RAY within 12 months

Form Completed by (Name and Title)_____ Date _____

Please note our email address is

cristina1.bini@uslnordovest.toscana.it

Tel no. +39.0586.223649/3208