

<b>H.-Hartziekenhuis Roeselare-Menen vzw</b> Wilgenstraat 2 8800 Roeselare tel. 051 23 71 11 fax 051 23 70 60 e-mail: <a href="mailto:info@hhr.be">info@hhr.be</a> <a href="http://www.hhr.be/">www.hhr.be/</a>	<b>Regionaal Ziekenhuis Jan Yperman vzw</b> Briekestraat 12 8900 Ieper tel. 057 35 35 35 fax 057 35 36 37 e-mail: <a href="mailto:informatie@yperman.net">informatie@yperman.net</a> <a href="http://www.yperman.net/">www.yperman.net/</a>	<b>AZ Sint-Augustinus Veurne</b> Ieperse Steenweg 100 8630 Veurne tel. 058 33 31 11 fax 058 33 30 11 e-mail: <a href="mailto:info@azsav.be">info@azsav.be</a> <a href="http://www.azsav.be/">www.azsav.be/</a>
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**Holiday hemodialysis**  
 Collective Autodialysis Veurne  
 Klinieklaan 1, B-8630 Veurne  
 Tel. 00 32 (0)58 33 38 20 of 00 32 (0)58 33 31 11 – Fax 00 32 (0)58 33 38 24  
 E-mail: [cad@azsav.be](mailto:cad@azsav.be)

**All the following filled in details must be faxed to 00 32 (0)58 33 38 24 or mailed to [cad@azsav.be](mailto:cad@azsav.be) at least 4 weeks before the first holiday dialysis.**

## **PART 1: DETAILS TO BE FILLED IN BY THE PATIENT**

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### **A. Personal details**

Name (maiden name)	First name:
Street:	Nr.:
Postal number:	City:
Country:	Nationality:
Telephone number:	Portable phone:
E-mail:	Date of Birth:
Speaking language(s):	

**Please send us also a copy of your passport (both sides please)**

### **Current dialysis centre**

Name dialysis centre:	
City:	Country:
Telephone number:	Fax:
E-mail:	
Treating doctor:	

## B. Holiday details

Holiday streetname:		
Postal number:	City:	
Telephone number:		
Duration holiday dialysis:		
First dialysis on:		
Last dialysis on:		
Preference for	<input type="checkbox"/>	morning Monday / Wednesday/ Friday
	<input type="checkbox"/>	afternoon Monday / Wednesday/ Friday
	<input type="checkbox"/>	morning Tuesday / Thursday/ Saturday
Because of organizational reasons, we can propose you another shift of dialysis.		
Who to inform if difficulties during the holiday? (name, address, telephone number)		

## C. (National) Health service or insurance details

<b>For Belgians:</b>
Name + number health service (SIS-card):
Name
Badge health service:
<b>For foreigners:</b>
E111 of Eurocross-card to send to us please

## D. Transport

The centre itself has to guarantee the transportation arrangement from and to the dialysis centre in Veurne and this through the patient's health insurance.
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## Part 2: TO BE FILLED OUT BY YOUR DOCTOR

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<b>Name patient:</b>	
Renal diagnosis:	
Recent problems / complications during dialysis:	
Date first dialysis:	
Other diagnoses / relevant medical anamnesis ( diabetes, pacemaker, hypertension, cardiac problems)	
<b>Bloodgroup:</b>	<b>Rh.</b>
Irregular antibody:	
allergy (antibiotics, other medication, contrast, food supplements, other,...):	
<b>Medication during dialysis:</b>	
<b>EPO:</b> (brand, dose, application): <u>must certainly be brought from your mother dialysis centre</u>	
<b>Iron:</b>	
<b>Vitamines:</b>	
<b>other:</b>	



<b>Anticoagulation artificial kidney:</b>	
Heparin, Fraxiparin, Clexane, Fragmin, Citrate, Imnohep, other	
Starting dose:	
Maintenance dose:	
<input type="checkbox"/>	Intermittent:
<input type="checkbox"/>	Continuous

<b>Vascular Access:</b>	
<b>AV fistel</b>	Native / artificial substance
	localisation:
	Unipuncture / bipuncture
	Metal needle / catheter      Diameter: (Gauge):
<b>Dialysiscatheter</b>	Type:
	localisation:
	Single lumen/dubble lumen
	How to fill the catheter?
	<input type="checkbox"/> Heparin pure      volume:
	<input type="checkbox"/> Heparin thinned out      volume:
	<input type="checkbox"/> Citrate      volume:
	<input type="checkbox"/> other      volume:

<b>Lab results: please give us the most recent results</b>	
<b>Transplant candidate:</b>	<input type="checkbox"/> yes
Transplant centre:	<input type="checkbox"/> No

**Stamp doctor, date, signature**