



Section 1 - DIALYSIS TREATMENT BOOKING REQUEST FORM

Full Name & Title (Mr,Mrs,Miss,etc) _____ Date of Birth _____ Hospital Number _____ Address _____ _____ Post Code _____ Home Telephone Number _____ Mobile Number _____
Name of Person to Notify in an Emergency / Next of Kin _____ Relationship to client _____ Address _____ Home Telephone _____ Mobile _____ Work Telephone _____
Name of Renal Unit _____ Address of Renal Unit _____ _____ Post Code _____ Renal Unit Telephone Number _____ Name of Holiday Co-ordinator _____ Ext. No. _____
Client GP Name _____ GP Address _____ _____ GP Telephone Number _____
HOLIDAY Address _____ _____ Telephone Number _____

Please circle your choice of holiday resort:

SKEGNESS / MILFORD-ON-SEA / SALISBURY / HAVANT

Please specify the dates that you require dialysis:

Total number of sessions _____

Please circle your preferred dialysis time AM / PM

(Please note that whilst we will try to accommodate your preference this cannot be guaranteed and will be dependant upon booking numbers at the time

IMPORTANT

Patients using our holiday centers must be screened negative to MRSA, Hepatitis B, Hepatitis C and HIV antigens within 1 month of their first dialysis session.

Please insure that all sections of the form are completed in full.

The following supportive documentation must also be forwarded:

- **Copies of original laboratory results for:**
 - **Nose swab certifying MRSA negative**
 - **Groin swab certifying MRSA negative**
 - **Serology result certifying Hepatitis B antigen negative**
 - **Serology result certifying Hepatitis C antigen negative**
 - **Serology result certifying HIV antigen negative**

- **List of current medication signed by doctor**

- **Drug Prescription form signed by doctor**

- **Latest biochemistry and haematology results**

- **A copy of the last 3 treatments, flow sheets or treatment assessment sheets**

- **The patient is required to bring the prescribed doses of Erythropoetin Stimulating Agents and IV Iron**

Please note that if we do not receive all the required documentation we can refuse to treat patient.

Section 2 - DIALYSIS PRESCRIPTION FORM
(To be completed by a nurse or doctor)

Patient Name _____
Date of Birth _____ Hospital Number _____

Vascular Access Site and Type of Access _____

Fistula

Local anaesthetic used:
(eg Lignocaine 1% sc, EMLA)

Cannulation Needle Size:

Central Line

Please indicate if central line is:
Vascath / Permcath
Please specify central line **locking** solution used:

(Please note Heparin 5000iu/ml is used as standard.
Any alternative locking solution required must be
supplied.)

Any problems / additional useful information relating to fistula / central line:

Anti - coagulation Initial Heparin Dose _____

Hourly Heparin Infusion Rate _____ Heparin Stop Time _____
(Heparin 1000iu/ml is used as standard. Please specify any alternative solution (eg Tinzaparin) which must be
supplied)

Dry Weight / Target Weight (kg) _____ Dialysis Treatment Time (hours) _____
Please choose from the available dialysers. Please note if a different dialyser is required it
must be brought with the patient.

POLYFLUX 170H	POLYFLUX 210H
----------------------	----------------------

Preferred dialyser: _____

Please choose from available dialysate fluids.

Skegness only		
	1	2
K ⁺ (mmol/L)	2.0	2.0
Ca ²⁺ (mmol/L)	1.25	1.0
Glucose (g/L)	1.0	1.0

Milford/Havant/Salisbury		
	3	4
K ⁺ (mmol/L)	1.5	1.5
Ca ²⁺ (mmol/L)	1.25	1.5
Glucose (g/L)	2.0	2.0

Preferred dialysate fluid: _____

Average Blood Pump Speed ml/min _____ Dialysate Flow Rate _____

Profiling – please specify if sodium or weight loss profiling is required _____



DIALYSIS PRESCRIPTION FORM (continued)

Potential problems during dialysis (eg hypotension, cramp) _____

Validation that dialysis prescription is correct is required by Doctor / Senior Nurse in Charge

Signature _____ **Print Name** _____ **Date** _____

Section 3 - MEDICAL INFORMATION FORM
(To be completed by a nurse or doctor)

Patient Name _____ **Date of Birth** _____

Hospital Number _____

Brief Medical History _____

Length of Time on Dialysis _____

(Please note the patient must be medically fit for dialysis in a satellite setting with functioning vascular access)

Diabetic – Type I / Type II _____

Allergies _____

Any Mobility Restrictions _____

Section 4 – DRUG PRESCRIPTION CHART
(To be completed by the doctor)

Patient Name _____
Date of Birth _____ Hospital Number _____

Please complete the prescription section below if our nurses are required to administer any drugs during dialysis treatment eg Erythropoetin, central line locking solutions , anticoagulants.

Drug Prescription

Drug:													
Dosage:													
Route:													
Frequency:													
Signature:													
Date:													
Dr Name:													
Drug:													
Dosage:													
Route:													
Frequency:													
Signature:													
Date:													
Dr Name:													
Drug:													
Dosage:													
Route:													
Frequency:													
Signature:													
Date:													
Dr Name:													

DR Signature _____ **DR Name (please print)** _____

Date _____

DRUG PRESCRIPTION CHART - *continued*
(To be completed by the doctor)

Patient Name _____
Date of Birth _____ Hospital Number _____

Please complete the prescription section below if our nurses are required to administer any drugs during dialysis treatment eg Erythropoetin, central line locking solutions , anticoagulants.

Drug Prescription

Drug:												
Dosage:												
Route:												
Frequency:												
Signature:												
Date:												
Dr Name:												
Drug:												
Dosage:												
Route:												
Frequency:												
Signature:												
Date:												
Dr Name:												
Drug:												
Dosage:												
Route:												
Frequency:												
Signature:												
Date:												
Dr Name:												

DR Signature _____ **DR Name (please print)** _____

Date _____



Section 5 - DIALYSIS TREATMENT FINANCE FORM
(To be completed by the relevant department)

Patient Name_____	Date of Birth_____
Address_____	
_____ Postcode_____	
Hospital Number_____	
Total Number of Dialysis Sessions_____	

Costs:

£298 per dialysis treatment

£ 40 administration fee per booking

This is based on a bicarbonate dialysis session of up to 5 hours duration including provision of all consumables and solutions but excludes additional individual medications (eg erythropoietin, IV Iron).

Is the patient required to contribute to the cost of holiday sessions?	YES/NO
If yes please state the amount_____	
Name of Hospital NHS Trust responsible for payment	

Address of Hospital NHS Trust	

_____ Post Code_____	
PURCHASE ORDER NUMBER:_____	
(Bookings will not be accepted without a purchase order number)	
Invoice Address	

_____ Post Code_____	
By signing this form you are committing your organization to the cost for the treatments stated above, administration fee and dialyser cost (if applicable).	
Authorised Signature_____	Date_____
Print Name_____	Job Title_____



CANCELLATION OF YOUR DIALYSIS TREATMENT BY:

You, (the client for whom dialysis treatment is required), or the clients doctor/consultant, health authority/NHS Trust/P.C.T. (or similar funding authority) or any person representing you and/or booking.

It may be necessary to cancel your holiday haemodialysis due to changes in circumstances, i.e. accident or illness. Once you know your dialysis will need to be cancelled, please telephone us on 020 7222 3014 to advise us verbally and then please confirm the instruction to cancel in writing. If you have taken out insurance for your holiday you will also need to advise the Insurance Company of the cancellation.

Cancellation charges are calculated from the dates that written instructions are received. The amount payable is as follows:

**From the date of booking and up to 3 weeks before dialysis treatment is due to start:
CANCELLATION FEE OF £40 IS PAYABLE**

**Less than 3 weeks before dialysis is due to start:
CANCELLATION FEE OF £100 IS PAYABLE**

**Non attendance:
TOTAL COST OF TREATMENT BOOKED**

PLEASE NOTE: Our Terms & Conditions of payment of treatment is strictly **30 days** net of invoice being sent out

CANCELLATION OF YOUR DIALYSIS TREATMENT BY RENAL SERVICES:

The company may have to cancel treatment due to circumstances beyond its control. In such circumstances where we have to cancel your booking we will endeavour to offer you alternative dates for your treatment.