ELSAN

POLYCLINIQUE MÉDIPÔLE SAINT-ROCH

«VACATION HEMODIALYSIS RECORD»

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Office nursing, quality and safety of care

Reference: form dia/DOC/226 – June 2020 – V2

HEMODIALISIS CENTER SAINT-ROCH

Polyclinique Médipôle Saint-Roch
Avenue Ambroise Croizat
66 330 CABESTANY
dialyse.vacances@medipole.fr

Cabestany, ………… / ………… /…………

The receiver:

Medical secretar yapen at 2 P.M

04.68.66.12.00

Dialysis file of ……………………………………………………………………………… for holydays.

We have received a request for you for dialysis during your stay for the period of ………… / ………… /…………

Please take a moment to complete the information below:

- ⇨ **Personal data form with a list of mandatory document to join**
- ⇨ **Medical form that will allow us to best accommodate your needs for dialysis.**

All the document must be completed by your nephrologist.

Please join to the file:

- ⇨ Lasted blood test results
- ⇨ Recent serology results (3 months)
- ⇨ Blood group card
- ⇨ Prescription of medical treatment
- ⇨ Photocopy of both sides of your ID card and European health insurance card
- ⇨ ID photo
- ⇨ One week old EPC results (carbaperemase Producer enterobacter)

After receiving your duly completed file and the nephrologist's consent, we will send you a letter of confirmation for your stay, within 4 weeks prior to your arrival.

In the meantime, please accept our greetings.

Elodie BORONAD / Séverine TORRES

Responsable of unit care / Nurse referent

❖ Personal data form

Last name: .... First name: ....

Maiden name: ....

Birth Date: .... / .... /........... Nationality: ....

Phone number: ..../......../......../......../........ Mobile number: ..../......../......../......../........

Insurance policy holder's name and birth date: ....

....

Name and address of your social security administration: ....

Your social Security number: ..../......../......../......../......../........ /........

❖ Address and phone number of your stay (holyday place): ....

....

......../......../......../......../........

❖ Usual means of transportation:

☐ Your personal car ☐ Taxi ☐ Ambulance (stretcher transportation)

Have you applied to other dialysis center: ☐ Yes, Wich one: ....

☐ No

❖ Usual dialysis mode:

☐ Dialysis Center (with a nephrologist present)

☐ Limited care dialysis (with a nephrologist visiting)

☐ Limited care dialysis (without a nefrologist)

☐ Home dialysis

Nephrologist's name and phone number: ....

......../......../......../......../........

PROTOCOL OF DIALYSIS

Name: .... First name: ....

Date of birth: .... / .... / ....

Address: ....

....

N° tél : - Home : ..../........../........../........../..........

- Portable: ..../........../........../........../.......... Fax : ..../........../........../........../..........

First dialysis:

FAV / site	Prothesis / site	Cathéter / site

Mode of puncture and needles used:

- One needle : G
- 2 needles : G (aiguille artérielle)
  : G (aiguille veineuse)

Dialyseur:

Membrane:

Advers indication of type membrane? :

Surface:

ANTICOAGULATION	Type : HBPM / doses : Standard / doses :

Conductivity :	Bicarbonate :

During of séances:
Weight:
Flow pump has blood:
Blood pression for séance:
Blood pression after séance:
Serum of restitution:

Viral serology of less than 3 months	
Antigène HbS :	Result of : .... / .... / ....
Anticorps anti-HbS :	Result of : .... / .... / ....
Value Ac anti-HbS :	Result of : .... / .... / ....
Anticorps anti-HbC :	Result of : .... / .... / ....
HCV :	Result of : .... / .... / ....
VIH 1 et 2 :	Result of : .... / .... / ....

OBSERVATIONS: ....

....

Signature and seal of the doctor:

INFECTIOUS STATUS

Name: .... **First name:** ....

Age: ....

- Is the patient covered by additional hygiene precautions? If yes, what type?

☐ CONTACT ☐ GOUTELLETTE ☐ AIR

Please specify which is the pathogen: ....

Site: ....

- Has the patient been hospitalized / dialyzed abroad in the previous 12 months? (Include any medical repatriation)

☐ YES ☐ NO

If yes, in which country ....

- Does the patient have a history of carrying (or contacting) a highly resistant bacteria?

☐ YES ☐ NO

If yes which one..

☐ Screening by co-culture or rectal swab

⇨ How much screening has the patient received? ....

⇨ What is the date of the last screening? ....

☐ Prophylactic isolation of CONTACT type.

I have taken note that I agree to report any change in the patient's status before his arrival.

MEDICAL OPINION

NAME:	Medical summary supplemented by:
First name:	Doctor: ....
Age:	Tél: ..../........../........../........../..........

DIAGNOSTIC OF NEPHROPATHY / HISTORY OF THE DISEASE

CURRENT PROBLEMS

DRUGS DURING THE SESSION

OTHER DRUGS

PATIENT CONSENT

I, the undersigned, Madam, Miss, Sir ....

Born : ....

1. Declare having been informed by my referent nephrologist of the modalities of practices of extra renal purification in hemodialysis, in structure “UDM”, autodialysis or in center and address all the necessary administrative and medical information at the medical establishment.

2. Declare having been informed that a doctor is at my disposal for any further information.

3. Declare having been informed of the benefits and risks specific to extra-renal purification which have been explained to me by my referent nephrologist.

4. Declare having been informed that the autodialysis works in the presence of a nurse but without a permanent medical presence.

5. Agree to send serological exams less than 3 months old (Hepatitis B, C, HIV) prescribed as part of my dialytic monitoring before my stay.

6. Accepts a possible return to the hemodialysis center in the event of a medical or technical complication.

7. Agree to come to all the prescribed dialysis and agree to notify the nephrologist doctor of the establishment, as soon as possible, in the event of incapacity.

8. Declare having been informed of possible changes in dialysis schedule / day of dialysis during the stay according to the schedule.

PATIENT SIGNATURE PRECEDED BY THE WORDS "READ AND APPROVED"

DATA COLLECTION

Last name: .... First name: ....

Maiden name: ....

Birth Date and place: .... / .... / ....

Address: ....

....

Phone number: ....../....../....../....../...... Mobile number: ....../....../....../....../......

Admitted to the healthcare for:

☐ Hospitalisation ☐ Ambulatory care ☐ Emergency

☐ I designate as support person (person you trust for medicals decision)

Last name: .... First name: ....

Maiden name: ....

Birth Date and place: .... / .... / ....

Address: ....

....

Phone number: ....../....../....../....../...... Mobile number: ....../....../....../....../......

You support person, legaly capable of, is

☐ A relative ☐ A close friend ☐ A family doctor

☐ I wish that this person by stand me in all formalities and health realated decisions during my stay.

I've been informed that the decision will last for the entire duration of my stay.
I can revolve the designation anytime and if I do, I am obliged to inform the healthcare clinic, in writing.

☐ I don't want to designate a support person (person you trust for medicals decisions)

Date: .... / .... / .... Signature:

ADVANCE DIRECTIVES

Any person of full age can write advance directives: this is a written declaration which specifies the wishes regarding their end of life, in so far as they would not be able to express their will.
They are taken into account for any decision concerning the cessation / limitation of unnecessary treatment or the artificial maintenance of life.
They can be modified / revoked at any time.

- I do not wish to write “advance directives” to date.
- I wish to write advance directives. (If you need further explanations, get in touch with the healthcare team.)