

DIALYSIS UNIT VISITING PATIENT FORM

Date _____

PATIENT INFORMATION

First name _____ Last name _____ DOB _____
Country _____ Home address _____
E-mail _____ FAX _____
Phone & address in Japan _____
Treatment dates requested _____
Primary language _____ Second language _____

DIALYSIS INFORMATION

Date of initial dialysis _____ Vascular access right left
Dialyzer type _____ Surface area _____m² Needle size _____
Dialysis frequency _____times/ week Duration of dialysis _____hours
Blood flow rate _____ml/min Venous outlet pressure _____mmHg
Dry weight _____kg Heparin: initial _____IU, maintenance _____IU/hour
Medications received during dialysis _____
Referring doctor's name and affiliation _____
Home dialysis unit address _____
Problems during dialysis _____
Special needs? _____

GENERAL MEDICAL INFORMATION

Primary diagnosis _____ Diabetes? Yes No
Pertinent secondary diagnosis _____
Contagious diseases including hepatitis _____
Medication allergy _____
Home medications _____
Other medical problems _____



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