腎科透析中心
Renal Dialysis Centre

Haemodialysis Medical Summary Sheet (For Tourist)

Identification Data		
Patient's Name (Mr./Mrs./Ms./Miss) _____		
Date of birth:_____(dd/mm/yyyy)	Age:_____	Sex: M / F
Home Address:		
Home Phone no.:	Mobile:	
E-mail:	Fax:	
Address in Hong Kong: Phone no. in Hong Kong:		
Emergency Contact Next of Kin:	Relationship:	Phone number:

General Medical information:			
Diagnosis:			
Underlying Diseases:			
Allergies	☐ Yes, Please specify:	☐ No	☐ Not Known

Dialysis Treatment Dates Requested		
No. of Treatment sessions in Hong Kong:	Treatment Schedule:	
	☐ Mon/Wed/Fri	AM (starts before 8:00 am) / PM (starts before 2:00 pm)
	☐ Tue/Thur/Sat	AM (starts before 8:00 am) / PM (starts before 2:00 pm)
Arrival Date:_____(dd/mm/yyyy)	Departure Date: _____(dd/mm/yyyy)	
First Treatment: _____(dd/mm/yyyy)	Last Treatment: _____(dd/mm/yyyy)	

16/F, Li Shu Pui Block, 2 Village Rd., Happy Valley, H.K.
Tel: (852)2835 8926 / Fax: (852)2892 7524
E-mail: RDC@hksh-hospital.com

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Haemodialysis Medical Summary Sheet (For Tourist)

Specific Haemodialysis Data:		
Date Dialysis Initiated:_____ (dd/mm/yyyy)	No. of Sessions per week :_____	Duration of Dialysis : _____hrs/session
Type of Dialyzer:	Surface Area:	
Dialysis Prescription: ☐ HD ☐ HDF (Pre /Post dilution)	Blood Flow Rate (ml/min):	
Vascular Access: Fistula / Goretex graft / Catheter Site_____	Type of Needle: _____	
Average BP Pre-dialysis /	Average BP Post-dialysis: /	
Dry Weight (kg)_____	Average Interdialytic weight gain:_____	
Dialysate: Bicarbonate: _____Na:_____ K: _____ Ca: _____ Glucose: _____	Dialysate Temperature:_____ Auto flow / Dialysate Flow Rate_____(ml/min)	

ANTICOAGULATION

Heparin / LMWH / Others: _____

Initial Dose_____	Hourly Dose_____	Heparin stopped _____mins before end

Special Dialysis Requirements/ Complications

Valid Laboratory Report

The following tests **MUST BE** done *within 4 weeks prior to visitor's requested date* and **MUST BE** emailed / faxed to our hospital when accepting the booking.

Test items:

- ✓ ***HIV***
- ✓ ***HBsAg***
- ✓ ***HBsAb***
- ✓ ***Hepatitis B core Total Antibody***
  (If Hepatitis B core Total Antibody positive, please check HBV DNA Quantitative PCR)
- ✓ ***ALT***
- ✓ ***HCV-Ab***
  (If HCV-Ab positive, please check HCV Quantitative PCR)
- ✓ ***Microbiology: Nasal Swab for culture & sensitivity***

This form must be accompanied by copies of the following information for confirmation of booking and appointment date(s).

1. Valid Laboratory Report
2. Medical Letter from referring Nephrologist / Doctor
3. Current medication chart (Signed by a medical officer)
4. Three recent dialysis treatments sheets.
5. Blood test reports, including Complete Blood Count (CBC), Renal Function Test (RFT), Liver Function Test (LFT) and biochemistry within 1 month
6. Vascular access operation record and condition

Please note:
Please send the above requested information to us. We are not able to confirm the treatment without them.
Please send or fax this form with appropriate documents to RDC@hksh-hospital.com / (852) 2892 7524.

RDC.038.H/E-06-062025 16/F, Li Shu Pui Block, 2 Village Rd., Happy Valley, H.K.
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