Dialysis Center | Visitor Information

This information will help us to prescribe patient's treatments as he/she normally takes them at his/her dialysis center; it must be filled out by the treating physician or renal nurse. Contact us for doubts or concerns.

Patient

Full Name

Residence Country City/State

Date of Birth Day Month Year

Phone

Email

Sex

Female

Male

Current Dialysis Provider

Facility Name

Contact Name

Phone Email

Dialysis Prescription

Vascular Access

Catheter

Fistula

Graft

Needles

15G

16G

17G

Heparin

Load

Hourly

Treatment Length (min)

Treatment Frequency

Dialyzer

Dialisate Temp (°C)

Blood Flow Rate

Dialysis Flow Rate

Dry Weight (kg)

Height (m)

Max UF (l)

K

CNa

Ca

Known Allergies

Medications

Comments and/or Additional Notes

Please adjust the following medical information with this format

Please complete this form with the following patient medical information. You may give a physical copy to the patient or send it scanned in a PDF file to our email. Please see our privacy notice on the WEB page. Thank you!

- Recent monthly labs
- Viral panel (serologies) hepatitis B, hepatitis C, HIV
- Last 3 recent dialysis flow sheets

Signature and/or stamp of the Doctor, RN, or dialysis center

contact@soundialys.com travelondialysis@soundialys.com www.soundialys.com

Ave. De Los Tules 168-10, Las Aralias. Puerto Vallarta, Jalisco 48328 Mexico.

Phone **+52 322 293 6906** | WhatsApp **+52 322 120 9824**