

**Visitor  
Dialysis Referral  
Form**



Wellington Dialysis Unit  
Capital Coast Health Ltd.  
Wellington.  
Phone No: ( 04) 385 5980  
Fax No: ( 04) 385 5521

Referral from:

Patient name:

Patient Sticky

Contact Ph and address while in Wellington:

**Dialysis Information.**

Date of last treatment		Access:		Target Weight	
Dialyser:		Dialysate:		Hours:	
Sessions per week:		Average Fluid gain:		Average Blood pressure:	
Heparin : Loading dose: Pump: Off time:		Date of next treatment after visit:			

Comments:

**Level of independence.**

Sets up own pack:	<input type="checkbox"/>	Sets lines on machine:	<input type="checkbox"/>	Removes own needles:	<input type="checkbox"/>
Administers own local:	<input type="checkbox"/>	Puts in own needles:	<input type="checkbox"/>	Self administers Eprex:	<input type="checkbox"/>

**Medical History:**

Primary Diagnosis:	
Allergies:	
Other Significant Problems:	

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**Serology.** Results need to be within 1 month of visit. MRSA needs to be within 4 weeks of visit please. VRE for visitors outside of New Zealand

<b>Hep B S Ag</b>			<b>Hepatitis C</b>		
<b>Hep B S Ab</b>			<b>HIV</b>		
<b>Anti HBC</b>			<b>MRSA</b>		
<b>VRE</b>					

**Hard copies need to be sent with referral please.**

**Bloods:** Recent blood results

	Date	Result		Date	Result
<b>Na</b>			<b>K+</b>		
<b>Urea</b>			<b>Creat</b>		
<b>Ca</b>			<b>PO4</b>		
<b>Hb</b>					

**Current Medications** All medications must be brought by patient, including Eprex and Iron requirements.


**General**

<b>Comments:</b>	
<b>Medical Referral Completed by:</b>	<input type="checkbox"/>
<b>Nursing Referral Completed by:</b>	<input type="checkbox"/>
<b>Date:</b>	