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:	☐	**Sets lines on machine:**	☐	**Removes own needles:**	☐
Administers own local:	☐	**Puts in own needles:**	☐	**Self administers Eprex:**	☐

Medical History:

Primary Diagnosis:	
Allergies:	
Other Significant Problems:	

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

Hep B S Ag			**Hepatitis C**		
Hep B S Ab			**HIV**		
Anti HBC			**MRSA**		
VRE					

Hard copies need to be sent with referral please.

Bloods: Recent blood results

	Date	Result		Date	Result
Na			**K+**		
Urea			**Creat**		
Ca			**PO4**		
Hb					

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

General

Comments:

Medical Referral ☐
Completed by:
Nursing Referral ☐
Completed by:
Date: