Request for Haemodialysis Treatment at Nephrocare Auckland Dialysis Unit; Auckland, New Zealand

Provider: KidneyKare Limited.
Dialysis Site: 29 Hain Avenue, Mangere, Auckland.
Medical Director: Dr David Voss ED*** BSc MBChB FRACP MRCP(UK) RNZAMC
Coordinator: Mrs Christine Davies.

Thank you for your interest in our haemodialysis unit. To enable us to provide the best care to you or your patient(s), it is important to read the below information and correctly and completely the attached health questionnaire.
We do not offer haemodialysis date(s) and time(s) until the correctly completed health questionnaire is received by us (including all laboratory results requested). Our Medical Director will then review your request and you will be advised if we are able to accommodate you. We will usually be able to advise you within two days of receipt of your correctly completed request. If you accept the haemodialysis schedule offered, a confirmation deposit will be required to confirm your booking. Confirmation payment is the cost of one treatment. This deposit is non-refundable. You are recommended to purchase travel insurance, including cover for loss of deposits, ill-health, medical care, hospital care and travel disruption.
Your confirmation deposit will be credited against the first treatment, if you keep the booking made. Payment is always required in advance. If payment is not received in full prior to your treatment, you will not be able to receive the haemodialysis treatment.
Payment schedule

Number of treatments	Deposit and confirmation payment (equivalent of one treatment cost)	Balance due
Up to 3	On booking, or no later than one week before first treatment	Before end first treatment
4 to 6	On booking, or no later than one week before first treatment	Before end of second treatment
6 to 13	On booking, or no later than one week before first treatment	Before end of third treatment
More than 13	On booking, or no later than one week before first treatment	Monthly in advance, no later than one week prior to treatment month

The cost per treatment up to 4.5 hours duration for non-New Zealand residents is $880.00 including GST.
Dialysis session for more than 4.5 hours carries an additional charge of $110 (including GST) per hour or part hour thereof.
All payments may be made in cash, local or international bank draft cheque, or EFTPOS. Payment by credit card and/or personal cheque is not available. Payment on your behalf by a sponsor in New Zealand is also acceptable.
A multi-resistant infection (eg. MRSA, ESBL or VRE) levy maybe incurred of $135.00 (including GST) per haemodialysis treatment and is additional to the cost per treatment fee if you / your patient is positive or status unknown at time of commencement of haemodialysis.
Your haemodialysis schedule is not confirmed until payment is received, and cleared. Normally we can confirm within one business days of receipt of payment.
GST (New Zealand Government goods and service tax) is 15%.
Prices may vary without warning; but once payment has been received, costs will not change.
If you have any questions or queries regards your booking, haemodialysis schedule or account, please contact the dialysis coordinator (Christine Davies) on +64 21 749768 or by e-mail dialysis@kidneykare.co.nz.

Thank you for considering dialysing at our unit.
1 June 2016

CONTACT DETAILS

(Please include country and area code for all numbers)

Your home dialysis unit

Contact person for clinical information (nurse or technician)

Name:____

Email: ____

Telephone: ____

Fax: ____

Nephrologist/Renal Physician or caring physician

Name:____

Email: ____

Telephone: ____

Fax: ____

General Practitioner

Name:____

Email: ____

Telephone: ____

Fax: ____

Dialysis Health Questionnaire

ONE COMPLETED QUESTIONNAIRE PER PATIENT PLEASE

Patient Details

Name: ____

Gender Male / Female (circle one option) Date of Birth: ____/____/_____ (DD MM YY) Age _____

Home Address ____

____

____

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____

Preferred **first** dialysis date in Auckland ____/____/____ (DD MM YYYY)
(please use correct date format)

Preferred **last** dialysis date in Auckland ____/____/____ (DD MM YYYY)
(please use correct date format)

Language ______________________________

English is the spoken language in New Zealand. We have some multi-lingual haemodialysis staff; please advise your preferred language. We do not guarantee your attending staff member will speak your requested language, but every effort within our power will be made to accommodate your language preference.

Auckland Contact Address

Name of contact (or Hotel) ______________________________________

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Telephone ____

Alternative contact ____

Office Use

Dates/times OK __________________ ______________________

Nurse __________________________ ______________________________

Accounts: DEPOSIT ADVANCE IN-FULL

Medical Questionnaire (Medical In Confidence)

(A recent medical report or letter by your usual attending nephrologist answering all these questions is an acceptable alternative to completing this medical questionnaire).

Cause of renal failure ____

____

Other Medical Conditions

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Medications ____

(Please include formulation; strength; dose frequency and route of administration)

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Allergies/adverse reactions ______________________________________

____

Dialysis Prescription

Access: FISTULA GRAFT Access Side: LEFT RIGHT
(Please circle correct option) (Please circle correct option)

Access Site: ARM THIGH Other ________________________________
(Please circle correct option) (Please specify site)

Goal / Dry Weight __________ kg Hours per session _____________

Dialyser membrane size $1.3m^2$ $1.6m^2$ $1.8m^2$ $2.0m^2$ Other ___________m^2
(Please circle correct option)

Dialyser membrane HAEMOPHANE PMMA POLYSULPHONE

Other membrane ______________________________ (please specify)

Fistula needle size 14G 15G Other________________ (please specify)

Blood flow ______________ ml/min Dialysate flow _____________ml/min

Dialysate potassium NIL 1.0 2.0 3.0 mmol/L Other ______________
(Please circle correct option)

Anticoagulant HEPARIN LMW heparin Other ______________
(Please circle one)

Dose (bolus) __________ Infusion Rate _____________ IU/hour

Other comments ____

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Laboratory Results
(All results must be performed within ONE MONTH prior to first haemodialysis with us)

Hepatitis B Antigen POSITIVE NEGATIVE Date ____/____/____
(please circle one option) DD MM YYYY

Hepatitis B Antibody POSITIVE NEGATIVE Date ____/____/____
(please circle one option) DD MM YYYY

HIV Antibody POSITIVE NEGATIVE Date ____/____/____
(please circle one option) DD MM YYYY

*ESBL swabs POSITIVE NEGATIVE Date ____/____/____
(please circle one option) DD MM YYYY

*MRSA swabs POSITIVE NEGATIVE Date ____/____/____
(please circle one option) DD MM YYYY

*VRE swab culture POSITIVE NEGATIVE Date ____/____/____
(please circle one option) DD MM YYYY

*MRSA Methicillin resistant *Staphylococcus aureus*
*VRE Vancomycin resistant *Enterococcus*
*ESBL Extended spectrum beta-lactamase resistance organisms

*** A certified copy of the laboratory result of the MRSA, VRE and EBSL results must accompany this request or the multi-resistant organism levy will be charged.**

Plasma Sodium ___________mmol/L Date ____/____/____ (DD MM YYYY)

Plasma Potassium _________mmol/L Date ____/____/____ (DD MM YYYY)

Plasma Urea _____________mmol/L Date ____/____/____ (DD MM YYYY)

Plasma Creatinine _________µmol/L Date ____/____/____ (DD MM YYYY)

Plasma Calcium __________mmol/L Date ____/____/____ (DD MM YYYY)

Plasma Phosphate ________mmol/L Date ____/____/____ (DD MM YYYY)

Plasma Albumin _____________g/L Date ____/____/____ (DD MM YYYY)

Haemoglobin _______________ g/L Date ____/____/____ (DD MM YYYY)

I declare that all the information above is correct and accurate to the best of my knowledge.
I acknowledge I am fully responsible for all costs associated with my health care.

Signature ______________________________ Date ____/____/____
DD MM YYYY