Egyptian Medical Services Co. (EMS)
11, Ebad Alrahman St., Sheraton Heliopolis,
11799 Cairo, Egypt
Tel.: +20 222 68 77 12/13
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reservation@ems-eg.com
www.ems-eg.com

TRANSIENT DIALYSIS PATIENT REPORT

PATIENT INFORMATION

**To be completed by the patient or their representatives on their behalf*

Surname:	**First Name:**	**Date of Birth** (DD/MM/YYYY)
Gender: ☐ Male ☐ Female		**Country:**
Mobile Number:	**E-Mail:**	
Home Address:		
Home Dialysis Center Name:	**Home Dialysis Center E-Mail:**	
Emergency Contact Name:	**Emergency Contact Phone:**	

TRAVEL DETAILS

**To be completed by the patient or their representatives on their behalf*

Holiday Destination:	☐ Hurghada	☐ Alexandria ☐ Luxor ☐ Aswan **Available only for group dialysis of minimum 5 patients*	
Date of Arrival (DD/MM/YYYY)**:**		**Date of Departure** (DD/MM/YYYY)**:**	
Preferred Day(s) of Dialysis:	☐ Mon-Wed-Fri	☐ Tue-Thu-Sat	☐ Every other day
☐ Other (please specify): _____			
Preferred Date(s) of Dialysis (DD/MM/YYYY) _____			
Dialysis Shift: **Subject to clinic's availability*	☐ 9:00 AM	☐ 2:00 PM	☐ 8:00 PM
Dialysis Type:	☐ HD-B (standard bicarbonate hemodialysis)	☐ HDF-B (bicarbonate hemodiafiltration)	

MEDICAL SUMMARY

**To be completed by the patient's treating nephrologist*

Date of Starting Dialysis (DD/MM/YYYY)**:**
Etiology of Renal Failure:
Comorbidities/Associated Medical Conditions:

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Drug Allergy:

Treatment Modality: ☐ Conventional ☐ High Flux ☐ High Efficiency **Usual UF Rate:** _____ mL/kg/hr

Home Dialysis Frequency: _____ sessions per week **Home Dialysis Duration:** _____ hours per session

Target Dry Weight: _____ kg **Usual Weight gain between sessions:** _____ kg

Blood Flow Rate: _____ mL/min **Dialysate Flow Rate:** _____ mL/min

Dialysate Rx

- Sodium: - K+: - Chloride: - Bicarb:
- Ca++: - Mg+: - Glucose: - Acetate:

If treated with *HDF: ☐ Pre-dilution ☐ Post-dilution

- Substitution Volume: _____ mL - Substitution Rate: _____ mL/min

Dialyzer

- Type: _____ - Surface Area: _____ - Type of Membrane: _____

Vascular Access

- Type: - Location: - Flow Direction:
- Needle gauge: - Local Anesthetic:
- Vascular catheter special flush instructions: _____

Anticoagulation Regimen

- Type: - Tradename:
- Bolus (units): - Maintenance (units/hr):
- If Pump: DC at _____ hr / _____ min before treatment termination

Blood Pressure: - Before Dialysis: _____ - After Dialysis: _____

Complications During Dialysis:

Medications During Dialysis:

1. Erythropoietin:
2. IV Iron:
3. Active Vitamin D:
4. Other: _____

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LATEST LAB RESULTS DATE (DD/MM/YYY) _____

**To be completed by the patient's treating nephrologist*

Sodium:	Potassium:	Calcium:	Phosphorus:
Creatinine:	BUN:	Hemoglobin:	HCT:
PT:	PTT:	PC:	INR:
IPTH:	Alkaline Phosphates:	Aluminum:	KT/V:
S. Iron:	Ferritin:	TIBC:	TSAT:
HbsAg:	HB Ab:	HCV Ab:	HIV Ab:
Blood Group:	Rh Factor:	MRSA Status:	

CURRENT MEDICATIONS

Medication Name	Dose	Route	Time Given	Notes

SPECIAL INSTRUCTIONS

IMPORTANT

- ***This report must be completed in English and signed by the attending physician. We can't accept an altered version.***
- ***If EPO, IV iron, active vitamin D, or any other supplementary medications are prescribed during dialysis sessions, patients are kindly requested to obtain them from their home hospital/clinic/dialysis unit pharmacy prior to arrival at EMS Dialysis Center.***
- ***HBsAg, HCV, and HIV that must be done on-site for all foreign nationals prior to the patient's first dialysis session, in accordance with the regulations of the Egyptian Ministry of Health & Population.***
- ***We are unable to accommodate Hep. B, HIV and/or MRSA positive patients as well as pediatric patients under 12 years old.***

Physician Name: _____ Hospital Stamp:

Signature: _____

**Please email the completed form to reservation@ems-eg.com*