States of Guernsey
Hospital Services

Holiday Haemodialysis Application Form

Patient Name: _____

Date of Birth: _____

Home Address: _____

_____

_____

Postcode: _____ Tel. No: _____

Holiday dates: _____

Holiday accommodation / address: _____

_____

Referring Unit/Hospital: _____

_____

Address: _____

_____

Postcode: _____Tel. No: _____

Email address: _____

By signing below you are confirming that the above named patient is medically stable, with established HD access and is fit to dialyse in a satellite unit.

Consultant's name: _____

Consultant's signature: _____ Date: _____

Patient Name: _____

GP Name and address: _____

_____

_____

Postcode: _____ Tel. No: _____

Person to Contact in an emergency_____

Address: _____

_____

Postcode: _____ Tel. No: _____ Mobile: _____

Relationship to patient: _____

Patient understands and speaks English? Yes/No

Dialysis Information:

Renal diagnosis: _____

Date patient commenced HD: _____ (at least 6 months)

Target weight: _____ Dialyser: _____

Hours per session: _____ Sessions per week: _____

Anticoagulation on HD: Heparin _____ Low molecular weight heparin _____

Bolus: _____Rate: _____ Stop time: _____ **NOTE: We are using Dalteparin Sodium (Fragmin) injection. If patient is using different anticoagulant, patient must bring in their own supply enough for the whole duration of the holiday dialysis with prescription on a drug card.**

Blood Flow Rate: _____ml/min Venous Pressure: _____

Max UF Rate / hour: _____ Profile: Yes _____ No _____

Average weight gain between dialysis session: _____

Average blood pressure: Pre HD: _____

Post HD: _____

Vascular Access type: _____

How long has the vascular access been in use? _____

Access condition: Good _____ Satisfactory _____ Poor_____

Needle size & length: _____

Local Anaesthetics: Topical cream _____ Lignocaine Injection_____

Nothing _____

Dialysate Content:

Potassium content: _____Calcium content: _____

Glucose content: _____

VIROLOGY STATUS: (Please attached official results)

	Results:	Date:
Hepatitis B Surface antigen (Hep BsAg)	_____	_____
Hepatitis C Antibodies (Hep C Ab)	_____	_____
Hepatitis C Viral Load (Hep C RNA)	_____	_____
HIV Test	_____	_____

OTHER INFECTION STATUS:

MRSA SCREEN (Nose & Groin)	_____	_____
CRE Anal Swab Screen (Carbapenemase Resistant Enterobacteriase)	_____	_____

BIOCHEMISTRY RESULTS: (Please attached official blood results)

Haemoglobin level:	_____	_____
Potassium level	_____	_____
Calcium level	_____	_____

DRUG ALLERGIES: _____

_____

MEDICAL HISTORY – please include any acute events that may have occurred in the past 6 months (please attached recent clinic letter).

Other relevant information / problems / complications on dialysis:

_____

_____

LISTS OF MEDICATIONS:

Erythropoeitin injection: _____ dose: _____

Iron injection: _____ dose: _____

NOTE: (Patient must bring in their own Epo injection with prescription)

MEDICINE	DOSE	FREQUENCY

Prepared by: _____ Date: _____

Signed: _____

Authorising Doctor's name & signature: _____

Date: _____

Infection Control Risk Assessment Information

We would be most grateful if you would complete the information below and Fax the form to us 01481 707475, or email to renalunit@gov.gg.

1. Do you dialyse Hepatitis B patients? YES/NO If yes are they dialysed in a separate room? YES/ NO

2. Do you dialyse Hepatitis C Positive patients? YES/NO If yes are they dialysed in a separate room? YES/NO

3. Do you dialyse HIV positive patients? YES/NO If yes are they dialysed in a separate room? YES/ NO

4. Do you screen all your patients on a regular basis for Hepatitis B YES/NO

5. Do you screen all your patients on a regular basis for Hepatitis C YES/NO

6. Are your consumables single use only?

SIGNED……

Doctor in Charge / Holiday Dialysis Coordinator

Funding Certificate

(For Non-UK Residents)

Patient Name: _____

I hereby certify:

That funding will be available for the above-named patient to cover the cost of **(specify number)** _____ haemodialysis session/s at £410.00 per session whilst on holiday in Guernsey Channel Islands.

Name: _____ Signature: _____

Date: _____ Contact Number _____

Position: _____

Health Authority/Renal Unit: _____

Billing address: _____

_____

_____

Postcode: _____ Tel. No:_____

Authorisation Number: _____

Cost Centre or Order number: _____

Holiday dialysis will not be confirmed until this form is completed in full and returned to the Guernsey Renal Unit.

Tel: (+44) 1481 711495 / 1481225111

Please be aware:

Acceptance of your patient for holiday dialysis in Guernsey will be dependent on the following being satisfied:

- The patient has been stable on haemodialysis for a minimum of six months.
- Access is permanent, more than six months old and unproblematic.
- Renal Profile, Full Blood Count, HIV, Hepatitis B and C results, Hep C viral load and MRSA & CRE screen to be taken within 4 weeks prior to the requested holiday dates.
- All completed documentation to be sent to the unit no less than 2 weeks prior to the requested dates.

If documentation and results are not received within the allocated time frame, we may cancel your request.

Home units should inform us of any change in the patient's dialysis prescription, health status or access that may occur between the original booking and their holiday.

Please send documents by Fax or via email to:

Holiday Dialysis Coordinator

Renal Unit – Princess Elizabeth Hospital

Rue Mignot, St. Martins, Guernsey, Channel Islands, GY4 6UU

Tel # (+44) 1481711495 / 1481225111

Email address: renalunit@gov.gg