



Sils Services Ltd.  
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## Welcome to Sils Dialysis!

If you would like to have your dialysis treatment with us, please contact us directly at [info@silsdialysis.com](mailto:info@silsdialysis.com) as soon as you have your dates. It is very important that you book with us at least three weeks prior to your first dialysis treatment. There are four documents attached to this file (1 – 4 below) that we will need filled in by yourself and your present treatment provider:

1. Personal Information Form
2. Enclosures Form
3. Treatment Orders
4. Consent Form

Please send the above forms back to us completed at least three weeks before your first scheduled treatment.

Our rates will be communicated to you once you indicate your initial interest and the number of treatments you are planning to have with us. Please note that the rates will not cover emergency care costs that may be required. A deposit to secure your booking will be required and we will notify you of the amount once the dates have been set. If you have had any hospital admissions/procedures or change of management after booking with us or within one month of your departure date you should seek advice re: travel from your nephrologist.

We also offer a pickup service from the airport to your hotel and transport service to and from your hotel to our clinic at an affordable rate. Please contact me if you wish to take advantage of this offer. If you have any further questions or queries please do not hesitate to contact me. We truly do look forward to serving you!

Kind Regards,

Nurse Paula  
Head Nurse



**Personal Information Form**

Patient Name: \_\_\_\_\_

Citizenship: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Sex: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Mobile/Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Vacation Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Vacation Phone: \_\_\_\_\_

Exact Treatment Dates: \_\_\_\_\_

Preferred Time:      0530                      1030                      1400

**Referring Dialysis Unit Information**

Referring Unit Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Nurse: \_\_\_\_\_

Social Worker: \_\_\_\_\_

Nephrologist: \_\_\_\_\_

Key Contact Phone: \_\_\_\_\_

## Enclosures Form

### Enclosures

- Standing Orders
- Problem List
- Medication Record (include both Home and in-centre lists)
- Patient Care Plan (within last 6 months)
- Progress Notes

### Diagnostic Test (including copies of the following):

- Chest x-ray (within 6 months)
- MRSA Swabs (Nasal, CVC site and any wound site, within 3 weeks)
- EKG (within last 6 months)
- Hepatitis B (within last 2 months)
- Hepatitis C (within last 2 months)
- HIV (within last 6 months)
- Recent Lab results (CBC, Lytes, Ur, Cr, AST, ALT, Ca Ph, and Alb)
- Last three dialysis treatment records
- Allergies

Referral form completed by:

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Signature:

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Title:

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Date:

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## Treatment Orders

In Centre Hemo \_\_\_\_\_ Self-care \_\_\_\_\_ Home \_\_\_\_\_ Other \_\_\_\_\_

Dialyzer \_\_\_\_\_ Kuf \_\_\_\_\_ Surface Area \_\_\_\_\_

Times per week \_\_\_\_\_ Prescribed Treatment Time \_\_\_\_\_

Dialysate Rx: K+ \_\_\_\_\_ CA++ \_\_\_\_\_ Ramp Sodium \_\_\_\_\_ to \_\_\_\_\_

Heparinization: Bolus \_\_\_\_\_ Hourly \_\_\_\_\_ Discontinue at \_\_\_\_\_

Dry Weight: \_\_\_\_\_ Kg

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## Vascular Access

Vascular Access Type \_\_\_\_\_ Location \_\_\_\_\_

Usual Blood Flow \_\_\_\_\_

Usual Arterial Pressure \_\_\_\_\_ Usual Venous Pressure \_\_\_\_\_

Needle Gauge \_\_\_\_\_ Local Anesthetic \_\_\_\_\_

Other Special Cannulation Considerations i.e. self-cannulation: \_\_\_\_\_

Vascular Catheter special flush instructions: \_\_\_\_\_

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## Medications

Medications on Dialysis:

Name: \_\_\_\_\_

Home Medication List: \_\_\_\_\_

Allergies: \_\_\_\_\_



**Consent Form**

I \_\_\_\_\_ hereby consent to undergo hemodialysis at Sils Dialysis Clinic. I understand that the procedure and my care will conform to the Association for the Advancement of Medical Instrumentation (AAMI) and the Centre of Disease Control (CDC Atlanta, Georgia, USA).

I understand my health record shall be confidential, and no one will have access to it without my consent except health care staff involved in my care and health authorities specified by law.

I understand dialyzers, tubing and needles utilized in the provision of my hemodialysis therapy will not be reused or would not have been reused.

I further understand that by granting my consent for dialysis at Sils that I agree to hold and save harmless Sils Services Ltd., its staff and associates from any liability for any complications arising from the dialysis treatment or medical conditions that may occur between treatments.

I acknowledge that I have read the above consent and all other information regarding my dialysis treatment at Sils Services Ltd. and agree to comply with all policies and procedures.

\_\_\_\_\_

Signature of Witness

\_\_\_\_\_

Signature of Patient

\_\_\_\_\_

PRINT NAME

\_\_\_\_\_

PRINT NAME