Welcome to Sils renal care

If you would like to have your dialysis treatment with us, please contact us directly at 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,

Medical Office Manager
Keisha Lynch

Sils Services Ltd.
Corner of 3rd Ave, & Pine Rd,
Belleville, St Michael
Barbados, W.I.

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Fax: +1 (246) 228-4634
Mail: info@silsdialysis.com
Web: www.silsdialysis.com

Personal Information Form

SIS renal care

Patient Name _____

Citizenship _____

Place of Birth _____

Date of Birth _____

Gender _____

Home Address _____

_____

Mobile/Home Phone _____

Work Mobile/Phone _____

Email Address _____

Vacation Address _____

_____

Vacation Phone _____

Emergency Contact _____

Exact Treatment _____

Dates _____

Preferred Treatment Time | 05:30 | 10:30 | 14:00 |

Referring Dialysis Unit Information _____

_____

Referring Unit Name & Phone _____

_____

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 (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, sensitivity to food or inanimate material/matter
- When was the last time that access was evaluated for blockages?

Referral form completed by: _____

Signature _____

Title _____

Date _____

Patient Name _____

Date of birth _____

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.

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:_____

MEDICATIONS

Medications on Dialysis:

Name: _____

Home Medication List: _____

Allergies: _____

Consent Form

I _____ hereby consent to undergo hemodialysis at Sils renal care 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 release 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 consent form 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