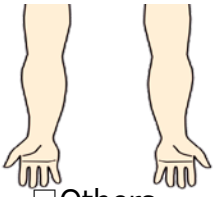
患者情報シート英語

Patient Information	Kinashi Obayashi Hospital			
Patient Name	Last	First	Sex	☐Man ☐ Female
DOB	/ / Day Month Year		Age	( )
Address				
ESRD Diagnosis	Primary			
	Secondary			
Allergies	☐YES ( )		☐NO	
Medical history of Hepatitis	Hep B	☐YES ( ) ☐ NO		
	Hep C	☐YES ( ) ☐ NO		
	Other	☐YES ( ) ☐ NO		
	(If Yes, about when)			
Medications				
Medications p.o.				
Intradialytic Medications				
( )	Dose ( )		Frequency( )	
( )	Dose ( )		Frequency( )	
Erythropoeitin	Dose ( )		Frequency( )	
Physician Summary				
(Please provide a summary regarding the patient, including the current disease conditions, complications, and psychological/behavioral issues that may concern with temporary dialysis to be performed in a foreign country. Moreover, please describe any specific issues relating to the patient's ECG readings and chest x-rays. Please provide the latest CTR value)				
ECG				
CHEST X-RAY				
CTR				
Mobility	☐Ambulatory ☐ Ambulatory with assist ☐ Wheel Chair			
Special Instructions				
(Unusual reactions/Special needs or circumstances relative to transient dialysis)				

Hemodialysis Summary			Kinashi Obayashi Hospital
Initial Dialysis Date	/ / Day Month Year		
Dialysis Time	HRS	Frequency of Dialysis	/week
Type of Dialysis	HD HDF Other( )		
Type of Dialyser/Console			
Surface Area	M^2	Blood Access ☐AVG ☐AVF ☐Subcutaneously fixed superficial artery ☐R Arm ☐ L Arm  ☐Others Methods of Hemostasis	
Blood Flow	ml/min		
Type of Needle			
Venous outlet pressure	mmHg		
Dry Weight	Kg		
Interdialysis weight gain	Kg		
BP Pre	mmHg		
BP Post	mmHg		
Usual UFR	ml/h		
Usual TMP	mm/Hg		
Dialysate	(製品名)		
Na+ K+ Ca++ Mg++ (mEq/L)			
Bicarbonate (mEq/L) Glucose (mg/dL)			
Heparin	Initial Dose	U	
	Maintenance	u/H	
	Time off	min. before HD closing time	
Others [ ]	Initial Dose	U	
	Maintenance	u/H	
	Time off	min. before HD closing time	
Respose to Drop in Blood pressure	☐Stop fluid removal ☐Raise Legs ☐Use vasopressor ☐Reinfusion of Saline solution ☐Others: ( )		

Laboratory Data				Kinashi Obayashi Hospital
Blood Type	☐A ☐B ☐O ☐AB			Rh: ☐(+) ☐(-)
Items	Results	Standard Level	Unit	Date Day / Month/ Year
BUN			mg/dl	/ /
Creatinine			mg/dl	/ /
Sodium(Na)			mEq/l	/ /
Postassium(K)			mg/dl	/ /
Chlorode(Cl)			mEq/l	/ /
Calcium(Ca)			mg/dl	/ /
Phosphorus(iP)			mg/dl	/ /
Albumen(ALB)			g/dl	/ /
AST(GOT)			IU/L	/ /
ALT(GPT)			IU/L	/ /
WBC Count			10^3/uL	/ /
RBC Count			10^6/uL	/ /
Hemoglobin			g/dl	/ /
Hematocrit			%	/ /
PLT Count			10^3/uL	/ /
HBsAg	☐(+) ☐(−)			/ /
HBsAb	☐(+) ☐(−)			/ /
HIV	☐(+) ☐(−)			/ /
HCV	☐(+) ☐(−)			/ /
RPR Test	☐(+) ☐(−)			/ /
VDRL	☐(+) ☐(−)			/ /

Please either fill out the form or send blood test results sheet with the information for the above tests.
Please send the results of the tests that must have been performed within three months of the planned date for the dialysis.

Referring Dialysis Unit Information			
Referring M.D.			
Hospital			
Address			
Email			
Phone		Fax	

I authorize the patient to receive transient dialysis in Japan, as phycian in charge, and send this patient information sheet.

Date:

Physician's Signature

Kinashi Obayashi Hospital Information			
Email	touseki@obayashihp.or.jp	Fax	+81-87-881-3867

The information contained on this sheet will be used for the sole purpose of reception checks at the facility the patient booked to have the dialysis and for the dialysis.
The sheet will not be used for any other use beyond the stated purpose
Please make sure that the email address or the fax number where you are sending your documents is correct. We are not responsible for any problems as a result of inadvertent transmission of your documents through email or fax.