SPECIFIC HEMODIALYSIS DATA No.2

Heparinnization(ヘパリン投与):

Initial dose(初期使用量): _____u

☐ Hourly dose (持続ヘパリン量/時): _____u/hour(u／時)

☐ Heparin intermittent(ヘパリン間欠投与): _____u Schedule:

Time off(ヘパリン終了時間): _____

Systolic/diastolic blood pressure(血圧):

Pre-dialysis (透析前): __/__mmHg Post-dialysis(透析後): ___/___mmHg

Dry weight (ドライウエイト): ____Kg Average weight gain(平均増加体重): ____Kg

Etiology of chronic renal failure (慢性腎不全の起因となった疾患):

Complications(合併症):

☐ EKG: _____

☐ Chest X-ray: _____

☐ CTR(心胸比): _____%

Medications list(定時処方薬):

_____

注意:日本の飲み薬を忘れずにお持ち下さい。 Note:Please bring your own supply of oral medication(s)

SPECIAL INSTRUCTIONS

Possible problems during session(透析中に起こりそうな問題):

Medications and treatments during or at the end of session(透析中又は透析後の投薬・処置):

_____

REFERRING DIALYSIS UNIT INFORMATION

Referring M.D. (主治医名): _____ Phone No.:

Referring hospital(病院名): _____ Fax No.: _____

Address(住所):

Date(日付): _____

As physician in charge, I authorize the above patient to receive dialysis treatment abroad.
(主治医として、上記患者が海外において透析治療を受けることを許可します。)

Physician's Signature(担当医署名): _____