Request for Haemodialysis Treatment at KidneyKare Dialysis Unit; Auckland, New Zealand

Provider: KidneyKare Limited.
Dialysis Site: 29 Hain Avenue, Mangere, Auckland.
Medical Director: Dr David Voss ED*** BSc MBChB FRACP MRCP(UK) RNZAMC
Coordinator: Mrs Christine Davies.

Thank you for your interest in our haemodialysis unit. To enable us to provide the best care to you or your patient(s'), it is important to read the below information and correctly and completely the attached health questionnaire.

We are a small unit, with only two chairs for simultaneous haemodialysis. If you have a group, please contact Chris Davies, dialysis co-ordinator (dialysis@kidneykare.co.nz) for possible options for larger groups.

We do not offer haemodialysis date(s) and time(s) until the correctly completed health questionnaire is received by us (including all laboratory results requested). Our Medical Director will then review your request and you will be advised if we are able to accommodate you. We will usually be able to advise you within two days of receipt of your correctly completed request. If you accept the haemodialysis schedule offered, a confirmation deposit will be required to secure your booking. Confirmation payment is the cost of one treatment. This **deposit is non-refundable**. You are recommended to purchase travel insurance, including cover for loss of deposits, ill-health, medical care, hospital care and travel disruption.

Your confirmation deposit will be credited against the first treatment, if you attend the booking(s) made. Payment is always required in advance. If payment is not received in full prior to your treatment, you will not be guaranteed to receive the haemodialysis treatment.

Advance payment schedule

Number of treatments	Deposit and confirmation payment (equivalent of one treatment cost)	Balance due
Up to 3	On booking, or no later than one week before first treatment	On booking, or no later than one week before first treatment
4 to 6	On booking, or no later than one week before first treatment	On booking, or no later than one week before first treatment
6 to 12	On booking, or no later than one week before first treatment	Before end of third treatment
13 or more	First session on booking, or no later than one week before first treatment	Monthly in advance, no later than one week prior to treatment month

The cost per treatment up to 4.5 hours duration for is $880.00 including GST. GST is the New Zealand Government goods and services tax (currently at 15%).
Dialysis session for more than 4.5 hours carries an additional charge of $110 (including GST) per hour or part hour thereof.
All payments may be made in cash, local or international bank draft cheque, or internet banking. Payment by credit card and/or personal cheque is not available. Payment on your behalf by a sponsor in New Zealand is also acceptable. Payments must be credited to the allocated New Zealand bank account – details are on the invoice.
A multi-resistant infection (eg. MRSA, ESBL or VRE) levy maybe incurred of $135.00 (including GST) per haemodialysis treatment and is additional to the cost per treatment fee if you / your patient is positive or status unknown at time of commencement of haemodialysis.

Your haemodialysis schedule is not confirmed until payment is received, and cleared. Normally we can confirm within one business days of receipt of payment.

Prices may vary without warning; but once payment has been received, costs will not change for those treatments remuneration has been received.

If you have any questions or queries regards your booking, haemodialysis schedule or account, please contact the dialysis coordinator (Christine Davies) on +64 21 749768 or by e-mail dialysis@kidneykare.co.nz.

Some medications you are prescribed may be different or are not available in New Zealand – we recommend you bring with you all your own medications for brief visits (less than one month) to minimise disruption to your regular routine.

Thank you for considering dialysing at our unit.

25 October 2017

YOUR CONTACT DETAILS

(Please include country and area code for all numbers)

Your home dialysis unit

Contact person for clinical information (nurse or technician)

Name: _____

Email: _____

Telephone: _____

Fax: _____

Nephrologist/Renal Physician or caring physician

Name: _____

Dialysis Unit name: _____

Email: _____

Telephone: _____

Fax: _____

General Practitioner or regular Family Health Physician

Name: _____

Practice Name: _____

Email: _____

Telephone: _____

Fax: _____

Dialysis Health Questionnaire

ONE COMPLETED QUESTIONNAIRE PER PATIENT PLEASE

Patient Details

Name: _____

Gender Male / Female (circle one option) Date of Birth: ____/____/_____ Age _____
DD MM YY

Home Address _____

_____

_____

_____

_____

Preferred **first** dialysis date in Auckland ____/____/____
(please use correct date format) DD MM YYYY

Preferred **last** dialysis date in Auckland ____/____/____
(**please use correct date format)** DD MM YYYY

Language _____

English is the spoken language in New Zealand. We have some multi-lingual haemodialysis staff; please advise your preferred language. We do not guarantee your attending staff member will speak your requested language, but every effort within our power will be made to accommodate your language preference.

Auckland Contact Address

Name of contact (or Hotel) _____

_____

_____

_____

Telephone _____

Alternative contact _____

Office Use

Dates/times OK _____ _____

Nurse _____ _____

Accounts: DEPOSIT ADVANCE IN-FULL

Medical Questionnaire (Medical In Confidence)

(A recent medical report or letter by your usual attending nephrologist answering all these questions is an acceptable alternative to completing this medical questionnaire).

Cause of renal failure _____

_____

Other Medical Conditions

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medications _____

(Please include formulation; strength; dose frequency and route of administration)

_____

_____

_____

_____

_____

_____

_____

_____

Allergies/adverse reactions _____

_____

Dialysis Prescription

Access: FISTULA GRAFT Access Side: LEFT RIGHT
(Please circle correct option) (Please circle correct option)

Access Site: ARM THIGH Other _____
(Please circle correct option) (Please specify site)

Goal / Dry Weight: _____ kg **Hours per session**: _____

Dialyser surface area 1.4m^2 1.8m^2 2.2m^2 2.4m^2 Other _____m^2
(Please circle correct option)

Dialyser membrane: POLYSULPHONE OTHER

Fistula needle size 16G 15G Other_____ (please specify)

Blood flow _____ ml/min **Dialysate flow** _____ml/min

Dialysate potassium: 1.0 1.5 2.0 3.3mmol/L (Please circle correct option)

Other potassium level _____ (please specify)

Anticoagulant HEPARIN Dose (bolus) _____
(Please circle one)

Infusion rate _____ IU/hour

LMW (low molecular weight) heparin

Other anti-coagulant _____ (please specify)

Other comments _____

_____

_____

_____

_____

Laboratory Results
(All results must be performed within ONE MONTH prior to first haemodialysis with us)

Hepatitis B Antigen POSITIVE NEGATIVE Date ____/____/____
(please circle one option) DD MM YYYY

Hepatitis B Antibody POSITIVE NEGATIVE Date ____/____/____
(please circle one option) DD MM YYYY

HIV Antibody POSITIVE NEGATIVE Date ____/____/____
(please circle one option) DD MM YYYY

*ESBL swabs POSITIVE NEGATIVE Date ____/____/____
(please circle one option) DD MM YYYY

*MRSA swabs POSITIVE NEGATIVE Date ____/____/____
(please circle one option) DD MM YYYY

*VRE swab culture POSITIVE NEGATIVE Date ____/____/____
(please circle one option) DD MM YYYY

*MRSA Methicillin resistant *Staphylococcus aureus*
*VRE Vancomycin resistant *Enterococcus*
*ESBL Extended spectrum beta-lactamase resistance organisms

*** A certified copy of the laboratory result of the MRSA, VRE and EBSL results must accompany this request or the multi-resistant organism levy may be charged.**

Plasma Sodium _____mmol/L Date ____/____/____ DD MM YYYY

Plasma Potassium _____mmol/L Date ____/____/____ DD MM YYYY

Plasma Urea _____mmol/L Date ____/____/____ DD MM YYYY

Plasma Creatinine _____µmol/L Date ____/____/____ DD MM YYYY

Plasma Calcium _____mmol/L Date ____/____/____ DD MM YYYY

Plasma Phosphate _____mmol/L Date ____/____/____ DD MM YYYY

Plasma Albumin _____g/L Date ____/____/____ DD MM YYYY

Haemoglobin _____ g/L Date ____/____/____ DD MM YYYY

I declare that all the information above is correct and accurate to the best of my knowledge.

I acknowledge I am fully responsible for all costs associated with my health care.

Signature _____ Date ____/____/____ DD MM YYYY