

# CHECKLIST HOLIDAY DIALYSIS

Patient's name: \_\_\_\_\_ Patient's phone: \_\_\_\_\_ Relative's phone: \_\_\_\_\_

Patient's address: \_\_\_\_\_ ZIP: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

## INFORMATION FROM THE REFERRING CENTER

Center's name: \_\_\_\_\_ Phone: \_\_\_\_\_ Contact person: \_\_\_\_\_ Country: \_\_\_\_\_

Needs transportation:  Yes  No Address during holiday: \_\_\_\_\_

Start and final dates of the holiday period: \_\_\_\_\_

Date of 1<sup>st</sup> treatment: \_\_\_\_\_ Date of last treatment: \_\_\_\_\_ Number of performed treatments: \_\_\_\_\_

## AUTHORIZATION REFERRING CENTER

## CONFIRMATION PATIENT/CENTER

Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

## CLINICAL DATA:

Is the patient properly vaccinated against Hepatitis B?  Yes  No Last result of HBs Ag: \_\_\_\_\_ Date: \_\_\_\_\_

Period	Sampling data	Signature	HBs Ag	HCV	VIH	Signature	Clinical information
Before holiday							Received (data)
After holiday							Delivered (data)

Carry medication:  Yes  No EPO (units): \_\_\_\_\_ Fe: \_\_\_\_\_ VitD: \_\_\_\_\_ Others: \_\_\_\_\_

Treatment information consent delivered and personal data protection:  Yes  No Document delivered 1<sup>st</sup> visit:  Yes  No

## BILLING: ENTITY IN CHARGE OF THE COSTS (DOUBLE-CHECK THE VALIDITY OF ALL DOCUMENTS)

DNI/PASSPORT (Check photo):  Yes  No

S.S (Write no): \_\_\_\_\_ Copy of the National Health Insurance card:  Yes  No Copy of the European Health card:  Yes  No

PRIVATE: Insurance company: \_\_\_\_\_ Insurance company authorization:  Yes  No

Billing documents signed by patients (5 copies):  Yes  No Billing documents given to patient (2 copies):  Yes  No

Effective paid:  Yes  No

Billing amount: \_\_\_\_\_ Receipt in B. Braun account:  Yes  No