DIALYSIS CLINIC BARBADOS

Welcome to the Dialysis Clinic Barbados. Please read the following and fill out the necessary information.

Your Social Worker or Holiday Co-ordinator can assist you with this. If you have any disabilities or special needs, please remember to mention them. Our dialysis machines are Fresenius with a state-of-the-art water treatment system. Our water quality exceeds those recommended by international standards (AAMI and CDC). Optiflux dialysers are used at this clinic. If you require a specific dialyser, we ask that you bring your own. You are also required to bring your own medication. Remember to transport your erythropoietin in a cool container and we shall be happy to store it for you during your stay.

The following must be faxed one month prior to traveling in order to facilitate your treatment:

☐ Laboratory copies of HIV, Hepatitis and MRSA screens
☐ A drug prescription signed by your doctor
☐ A letter from your doctor confirming you are fit for travel and holiday dialysis.

Please contact us should you have any queries. Do not hesitate to ask if there is anything else that you would like us to do in order to make your stay a pleasant one.

Tel: 246 418 6519/91
Fax: 246 418 3343
info@dialysisclinicbarbados.com

DIALYSIS CLINIC BARBADOS

Information form

Client's name: Date of Birth:

Home Address:

Tel: E-mail:

Your Dialysis Clinic Name & Address:

Tel: Fax:

Next of Kin's name: Contact number:

Holiday Address in Barbados:

HIV: Date of last test D D/ M M / Y Y Result:

MRSA: Date of last screen D D/ M M/ Y Y Result:

Hepatitis B: Date of last test D D /M M /Y Y Result:

Hepatitis C: Date of last test D D /M M /Y Y Result:

I hereby certify that the above information is correct.

Name:

Date: Position:

Signature:

Please remember to fax copies of the laboratory results with this form. This form must be returned at least 4 weeks prior to travel. Fax: 246 418 3343.

TEL: (246) 418-6519/91 • FAX: (246) 418-3343
CORNER 4TH AVENUE DOVER • CHRIST CHURCH • BARBADOS • 15026
EMAIL: INFO@DIALYSISCLINICBARBADOS.COM
WWW.DIALYSISCLINICBARBADOS.COM

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Dialysis Prescription

Client's Name:

Dialysis Frequency: /week **Duration:** hours

Dry Weight: Average weight gain:

Access: ☐ fistula ☐ gortex ☐ permcath

Permcath Lock (mls): Arterial ☐ Venous ☐ Using heparin 5oooiu/ml

Needle size:

Average blood flow rate: **Average venous pressure:**

Heparin loading dose: **Maintenance heparin:**

Any Access Problems:

Allergies/problems with lignocaine:

Any problems on dialysis:

Any other problems:

Medications post-dialysis:

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Dialysis Dates

Client's name:

Duration of Holiday: **From** DD/MM/YY **To** DD/MM/YY

Preferred Days For Dialysis:

DD/MM/YY DD/MM/YY

DD/MM/YY DD/MM/YY

DD/MM/YY DD/MM/YY

DD/MM/YY DD/MM/YY

DD/MM/YY DD/MM/YY

DD/MM/YY DD/MM/YY

Preferred Time For Dialysis:

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