

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

Provider: Nephrocare NZ, Fresenius Medical Care (South East Asia) Pty Ltd.
 Dialysis Site: Building A, Ascot Park, 93-95 Ascot Avenue, Greenlane, 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 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 confirm 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 keep the booking made. Payment is always required in advance. If payment is not received in full prior to your treatment, you will not be able to receive the haemodialysis treatment.

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 | Before end first treatment |
| 4 to 6 | On booking, or no later than one week before first treatment | Before end of second treatment |
| 6 to 13 | On booking, or no later than one week before first treatment | Before end of third treatment |
| More than 13 | 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 non-New Zealand residents is \$750.00 excluding GST.

Dialysis session for more than 4.5 hours carries an additional charge of \$70 (excluding GST) per hour or part hour thereof.

There is an additional laboratory test levy of \$10 (plus GST) per haemodialysis treatment.

All payments may be made in cash, local or international bank draft cheque, or EFTPOS. Payment by credit card and/or personal cheque is not available. Payment on your behalf by a sponsor in New Zealand is also acceptable.

A multi-resistant infection (eg. MRSA, ESBL or VRE) levy maybe incurred of \$100.00 (excluding 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.

GST (New Zealand Government goods and service tax) is 12.5% until 30 September 2010.

GST (New Zealand Government goods and service tax) is 15% from 1 October 2010.

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

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.

Thank you for considering dialysing at our unit.

1 June 2010

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: _____

Email: _____

Telephone: _____

Fax: _____

General Practitioner

Name: _____

Email: _____

Telephone: _____

Fax: _____

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 membrane size 1.3m² 1.6m² 1.8m² 2.0m² Other _____ m²
(Please circle correct option)

Dialyser membrane HAEMOPHANE PMMA POLYSULPHONE

Other membrane _____ (please specify)

Fistula needle size 14G 15G Other _____ (please specify)

Blood flow _____ ml/min Dialysate flow _____ ml/min

Dialysate potassium NIL 1.0 2.0 3.0 mmol/L Other _____
(Please circle correct option)

Anticoagulant HEPARIN LMW heparin Other _____
(Please circle one)

Dose (bolus) _____ Infusion Rate _____ IU/hour

Other comments _____

Dietary requirements

(All food is applicable to dialysis patients)

VEGETARIAN VEGAN LOW CHOLESTEROL
(Circle one option)

Other _____
(Please specify)

Laboratory Results

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

Hepatitis A Antibody **POSITIVE** **NEGATIVE**
(please circle one option)

Date / /
DD MM YYYY

Hepatitis B Antigen **POSITIVE** **NEGATIVE**
(please circle one option)

Date / /
DD MM YYYY

Hepatitis B Antibody **POSITIVE** **NEGATIVE**
(please circle one option)

Date / /
DD MM YYYY

Hepatitis C Antibody **POSITIVE** **NEGATIVE**
(please circle one option)

Date / /
DD MM YYYY

HIV Antibody **POSITIVE** **NEGATIVE**
(please circle one option)

Date / /
DD MM YYYY

*ESBL swabs **POSITIVE** **NEGATIVE**
(please circle one option)

Date / /
DD MM YYYY

*MRSA swabs **POSITIVE** **NEGATIVE**
(please circle one option)

Date / /
DD MM YYYY

*VRE swab culture **POSITIVE** **NEGATIVE**
(please circle one option)

Date / /
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 will 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