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) FASDIN NZDSM 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 return the attached questionnaire correctly and completely.

We are happy to receive copies of the previous 3 dialysis schedules (no more please) for further information; but please **do not send them as a substitute for completing this form comprehensively.**

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 are the only private fee-paying haemodialysis (HD) unit in New Zealand – based in Auckland. If you are looking for HD elsewhere in New Zealand, you will need to contact the other location9s) directly. The website https://www.globaldialysis.com may be a good starting point.

We do not offer scheduled 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 (deposit) is the cost of one treatment. This **deposit is non-refundable**. 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 treatments, you will not be guaranteed to receive the haemodialysis treatment.

You are recommended to purchase travel insurance, including cover for loss of deposits, ill-health, medical care, hospital care and travel disruption; prior to your travel.

The dialysis unit is accessed from the building exterior by via three steps. There is no assisted access for wheelchair or similar reduced mobility of the dialysis patient. Unfortunately, currently, we cannot accept for treatment people requiring these mobility services or facilities.

1. Deposit is required no later than ten (10) business days prior to first dialysis.

2. The balance for remaining booked sessions must be paid for in advance, prior to first HD session.

3. Special payment allowances are considered for requests over one month of bookings (13 or more HD sessions). The dialysis co-ordinator will advise of the payment schedule on request.

The cost per treatment up to 4.5 hours duration for is $1,150.00 including GST. GST is the New Zealand Government goods and services tax (currently at 15%).

Dialysis session for more than 4.5 hours duration carries an additional charge of $150 (including GST) per hour or part hour thereof.

All payments may be made in local (NZ) or international bank draft 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 KidneyKare Dialysis Unit New Zealand bank account – details are on the invoice. International payments often take at least two days to clear by the receiving bank – it is advised to allow this extra time in your planning.

The full payment due must be received by KidneyKare Limited without deduction. Bank fees for transactions levied by banks (local or international transactions) are the payees' responsibility.

CoViD positive patients may be dialysed, however will be required to wear N95 or superior quality masks throughout their treatment. No mask exemption is permitted. If the dialysis patient cannot wear an N95 (or similar) mask, then we are unable to accommodate them for dialysis treatment sessions: until they are RAT (rapid Sars-Cov-2 antigen test) negative. We have RAT (rapid antigen test) kits and will test the dialysis patient as required.

Cancellation of a dialysis session may be made at least SEVENTY-TWO (72) hours in advance; such notice must be in writing to the dialysis co-ordinator (email or text is recommended). The dialysis co-ordinator will confirm receipt of the cancellation. Where appropriate a refund will be made less any administration levies. If you fail to attend a booked/confirmed haemodialysis session, the fee for that session will be forfeited. Extenuating circumstances will be considered, however the decision remains entirely at the discretion of our medical director.

We cannot safely accept the frequency of haemodialysis booked sessions less than three per week. Exemption from three standard haemodialysis (HD) sessions per week will require written evidence by your home dialysis unit (in the case of visitors from other countries) and approval remains entirely at the discretion of our medical director.

Your haemodialysis schedule is not confirmed until full 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 payment 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.

8 May 2024

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: _____

ONE COMPLETED QUESTIONNAIRE PER PATIENT PLEASE

THIS SECTION MUST BE COMPLETED

Please enter the date of your last HD at your home dialysis unit prior to travelling to our Auckland unit:

_____ / _____
(date) / (month)

Please enter the date of your first HD at your home dialysis unit following visiting our Auckland unit:

_____ / _____
(date) / (month)

Patient Details

Name: _____

Gender Male / Female Date of Birth: ____/____/_____ Age _____
(circle one option) 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 CUFFED tunnelled CVL catheter
(Please circle correct option)

Access Side: LEFT RIGHT
(Please circle correct option)

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

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

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

Dialyser membrane material: _____

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

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

Dialysate potassium: 2.0 3.0mmol/L (Please circle correct option)

Other potassium level _____ (please specify)

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

Infusion rate _____ IU/hour

Heparin OFF time _____ minutes prior to END of session

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

*CRE swab culture 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*
*CRE Carbapenem resistant *Enterobacter species*
*ESBL Extended spectrum beta-lactamase resistance organisms

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 be it related directly or not to my haemodialysis.

I acknowledge access to the dialysis unit is limited to people who are ambulatory; and there is no wheelchairs access.

Signature _____ Date ____/____/____
DD MM YYYY