HOLIDAY DIALYSIS

Dear,

You are planning on staying in our region and you want to be taken care of in a AGAHTIR hemodialysis unit.

The establishment has 3 units likely to accommodate you:

Assisted autodialysis unit 25 rue Barbéris 06300 Nice	Assisted autodialysis and medical dialysis units Centre Hospitalier de Grasse 28 Chemin de Clavary 06130 Grasse	Assisted autodialysis unit L'Olympia 601 avenue de Fréjus 06210 Mandelieu La Napoule

A team of qualified hemodialysis nurses ensures the installation of the equipment, the puncture of the vascular approach and the smooth running of the dialysis. Hemodialysis sessions take place without the continuous presence of a nephrologist, but he can be consulted if needed.

So that the file is complete, thank you to send us the following documents to the email address secretariat@agahtir.fr or by fax to 04.93.56.52.50:

- Administrative information
- Medical information (to be completed by your nephrologist)
- Personal medical treatment
- The result of serologies of less than 3 months
- The medical certificate of management in assisted autodialysis unit
- The informed consent form
- The appointment form of the person of trust
- A copy of the ID
- A certificate of social security coverage for the current year or a copy of the updated European card if you reside in the European Union

Upon receipt of the file, and after the decision of the nephrologist, a response to your request for care will be sent to you as soon as possible.

You will have to confirm your stay 2 weeks before your arrival, the sessions days and hours will then be passed on to you.

ADMINISTRATIVE INFORMATION

Surname :..…… First name : ……

Date of birth : ..…….... Place of birth : …….....

Home address :…….....

……

Phone :…….. Mobile :……...

Person to contact: ……..... Phone : ……..

Health insurance …….....

Social Security number: ……/……

Referring dialysis unit:…….....

Phone : …….. Fax :

……..….

Date of last session before going on holiday: ……..…….....

What will be your address in France during your stay? ……

……

Date of stay from : …… to : ……..

Prefered unit: □ Nice □ Grasse □ Mandelieu

Prefered days: □ Monday Wednesday Friday □ Tuesday Thursday Saturday

MEDICAL INFORMATION

Name : ..... First name : .....

Initial nephropathy: .....

Antecedents : .....

....

....

Date of first dialysis: .....

Degree of autonomy: □ Autonomous □ Moves with help □ Dependent

Dialysis information

Weekly frequency of sessions: ..... Duration : .....

Dialysate prescription Na : ..... K : ..... Ca : ..... Gluc : .....

Conductivity Na : ..... Conductivity HCO3 : .....

Dialyser : ..... Blood flow : .....

Vascular access : ..... □ Left □ Right

Needle type: ..... □ 17G □ 16G □ 15G

Uniponcture □ Yes □ No

Dry weight : ..... Average catch of weight : .....

Blood pressure before dialysis : ..... Blood pressure after dialysis : ....

Intradialytic blood pressure drop □ Yes □ No

□ Standard héparin Loading dose : ..... Continuous : .....

□ HBPM : ..... Dose : .....

□ EPO : ..... Posology : ..... Date of last injection: .....

□ Iron : ..... Posology : ..... Date of last injection: .....

□ Autre : ..... Posology : ..... Date of last injection: .....

ZA la Vallière – Bâtiment 3 – 06730 SAINT-ANDRE DE LA ROCHE
Téléphone : 04 93 26 32 32 – Télécopie : 04 93 56 52 50

MEDICAL CERTIFICATE

I, the undersigned, Doctor ....., Nephrologist, certifies that:

Mr/ Ms ..... can be taken in charge during his/her stay in your region:

□ in an assisted autodialysis unit (without continuous presence of the Nephrologist)

If necessary, a withdrawal into a dialysis center will be organized according to the capacity of reception. Repatriation may be considered before the end of the stay.

Made in ....., the ..... / ..... /.....

Signature and doctor's stamp

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DESIGNATION OF THE TRUSTED PERSON FORM

« In application of the law n ° 2002-303 of March 4, 2002 relating to the rights of the patients and the quality of the system of health and in particular of its article L.1111-6, any person over the age of majority can designate a person of confidence who can be a relative, a close friend or the attending physician, and who will be consulted in case she/he is unable to express her wishes and receive the necessary information for this purpose».

I, the undersigned,

Name: …… First name: ……

Born on ……/……/…… in ……..

Address: ……...

……

☐ **Wish to designate a trusted person** (either in the absence of a first appointment or in the place of the person previously designated):

Mr, Mrs,

Name: …… First name: ……..

Born on ……/……/…… in ……..

Address: …… ……..

.....

Phone: ……

Relationship with the person of trust (family member, attending physician): ……...

I wish that the person of trust accompanies me in my medical steps and attends the medical interviews to help me in my decisions:

☐ Yes ☐ No

☐ **Wish to revoke the trusted person named in the previous form, without designating a new one.**

☐ **Do not want to appoint a trusted person.**

Done in ..... , on .....

Signature of the patient Signature of the person of trust

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INFORMED CONSENT FORM
FOR THE CARING IN AN AUTODIALYSIS UNIT

I, the undersigned Name First name……....., born on……../……/……

give my agreement to be medically supported by AGAHTIR.

I authorize additional examinations and regular blood tests (including HIV and HCV serology) to be performed as part of the care provided within the facility.

I undertake to respect the rules related to the proper functionning of the service.

I give my consent to AGAHTIR to collect and use my personal data for exclusively administrative and medical purposes.

If necessary and in case of emergency only, I authorize the AGAHTIR to inform the following person(s):

Mrs/Mr ……...
Relationship…….....
Phone …….....

Mrs/Mr ……...
Relationship…….....
Phone …….....

Date : ..... Signature: (with the mention "read and approved")