

PATIENT INFORMATION SHEET

○Please fill in all English (すべて英語で記入してください)

Ogasawara Clinic

IDENTIFICATION DATA (一般事項)					
Patient's Name (氏名)		Date of Birth (生年月日)	DD/ /	MM/ /	YY
Dialysis Dates Requested (透析日)		Sex(性別)	M	-	F
Visiting Phone Number (緊急連絡先)					
HEMODIALYSIS DATA (透析治療について)					
Dry Weight (基本体重)	kg	Dialyzer (ダイアライザー)			
Type of Needle (針のタイプ)		Blood Flow Rate (血液流量)	mL/min		
Size of Needle (針のサイズ)		Blood Access (ブラッドアクセス)			
Heparinization:initial Dose (ヘパリン開始投与量)	iu	Heparinization: Hourly Dose (毎時間投与量)	iu/h	Heparin Stop Time (ヘパリン開始投与量)	/min before finish
Hours per Treatment (透析時間)	hours				
GENERAL TREATMENT INFORMATION(病歴について)					
ESRD Diagnosis(病名、原疾患)					
Pertinent Secondary Diagnosis(合併症)					
Contagious Diseases(感染症)					
History of Clinical Hepatitis(肝炎の病歴)					
History of Diabetes(糖尿病の病歴)					
Allergies(アレルギー)					
Medications received during dialysis (Dose,Frequency,Route)(透析中の投与薬剤)					
LABORATORY DATA(血液検査について)					
※Please submit copy of recent monthly lab results including HbsAg,HbsAb,HCV result.					
※Unusual events/problems during dialysis and comments.(透析中における特記事項)					