NATIONAL KIDNEY FOUNDATION OF SAMOA

(Established: National Kidney Foundation of Samoa Act 2005)

PO Box 611
Motootua,
Samoa

Tel: (685) 32-123 / 32120
Fax: (685) 32-231 /32-240
Website: www.nkfsamoa.org.ws

APPLICATION FOR HOLIDAY DIALYSIS

Thank you for your interest in choosing us as your treatment provider while on holiday in Samoa. To ensure that we are able to make your holiday dialysis enjoyable, please read the following carefully:
1. Please submit this form and confirm your dialysis dates at least 3 weeks prior to arrival. Upon arrival, please contact us at 685-32-123 (9 am to 3:00 pm) to reconfirm.
2. Compulsory payment by cash (SAT$500) is required before each dialysis treatment. A detailed receipt and report for refund of fees from Insurance providers is available on request.
3. Please fax your form to (685) 32-231 or 32-240.

APPLICANT'S INFORMATION

NAME: (Mr/Mdm/Mrs/Miss) _____

DATE OF BIRTH: _____ AGE: _____ SEX: FEMALE / MALE

NATIONALITY: _____ PASSPORT NO: _____

CONTACT NO: ( ) - _____ FAX NO: ( ) - _____

EMAIL ADDRESS: _____

HOME ADDRESS: _____

COUNTRY: _____ ZIP / POSTAL CODE: _____

HOLIDAY DIALYSIS INFORMATION

DATE OF ARRIVAL IN SAMOA: _____ DATE OF DEPARTURE: _____
(DAY/MONTH/YEAR) *(DAY/MONTH/YEAR)*

NAME OF HOTEL OR CONTACT PERSON IN SAMOA: _____

ADDRESS IN SAMOA: _____

CONTACT NO: ( ) - _____ FAX NO: ( ) - _____

EMAIL ADDRESS: _____

NO. OF SESSION(S) NEEDED: _____ FROM / ON: _____ TO: _____
(DAY/MONTH/YEAR) *(DAY/MONTH/YEAR)*

PREFERRED TIME/SHIFT:

Mon-Wed-Fri		**Tues-Thurs-Sat**	
Morning	Afternoon	Morning	Afternoon
6.00am	1300hrs	7.00am	1330hrs
7.30am	1330hrs	7.30am	1400hrs
8.00am	1400hrs	8.00am	1430hrs

PHYSICIAN'S PARTICULARS

PHYSICIAN'S NAME: _____

ADDRESS: _____

_____ZIP/POSTAL CODE: _____

CONTACT NO: ( ) _____ FAX NO: ( ) _____

** Charges quoted does not include costs of Medication.*

APPLICANT'S MEDICAL HISTORY (TO BE COMPLETED BY REFERRING DOCTOR)
(Please attach certified medical reports, blood tests results and heart report)

NAME OF APPLICANT: _____

PRIMARY DIAGNOSIS: _____

CO-MORBID CONDITIONS: _____

FORM OF ACCESS: _____ **FUNCTIONAL STATUS OF AV FISTULA** _____

BLOOD FLOW RATE: _____ **STATUS**: _____

ACETATE/BICARBONATE DIALYSIS *(please circle)* **FREQUENCY OF DIALYSIS PER WEEK**: _____

HEPARIN/FRAGMIN DOSAGE: _____**TYPE OF DIALYSER**: _____

NO OF DIALYSIS HOURS: _____ **DRY WEIGHT**: _____

HISTORY OF ETO AND OTHER DIALYSIS INCOMPATIBILITY: _____

_____

MEDICATIONS APPLICANT IS CURRENTLY ON (Dosage & Frequency): _____

_____

_____

APPLICANT WOULD REQUIRE SUPPLY OF MEDICATIONS*: NO / YES *(please list below)*

_____

DIALYSIS INDUCED SYMPTOMS : NEVER / RARELY / COMMONLY

HEPATITIS B S ANTIGEN : POSITIVE / NEGATIVE (Pls provide certified report)

HEPATITIS C ANTIBODY : POSITIVE / NEGATIVE (Pls provide certified report)

HIV STATUS (COMPULSORY) : POSITIVE / NEGATIVE (Pls provide certified report)

PLEASE INCLUDE RECENT COPIES OF BIOCHEMISTRY and HAEMATOLOGY RESULTS:

ANY INFECTIOUS DISEASE/S : NO / YES *(please list below)*
TREATMENT: _____

HEART DISEASE : NO / YES *(please list below)*
(pls provide scan report if any was done) *TREATMENT:* _____

RECENT ECG STATUS : _____

DIABETES : NO / YES *(please fill in below)*
TREATMENT: _____

MENTAL ILLNESS : NO / YES

_____ _____

PHYSICIAN'S NAME AND SIGNATURE
COMPANY STAMP

DATE

** Charges quoted does not include costs of Medication.*