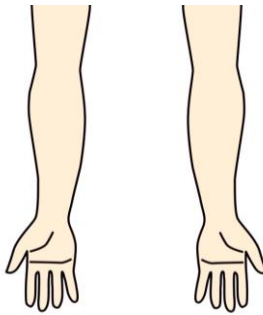


Patient Information(患者資訊)				
Patient Name (患者姓名)	Last (名)	First (姓)	Sex (性別)	<input type="checkbox"/> Man (男) <input type="checkbox"/> Female (女)
DOB (生日)	Day(日) /	Month(月) /	Age (年齡)	Year(年)
Address (住址)				
ESRD Diagnosis (原發性疾​​病)	Primary (繼發症)			
	Secondary (後遺症)			
Allergies (有無過敏)	<input type="checkbox"/> YES ()			<input type="checkbox"/> NO
Medical history of Hepatitis (肝炎感染病史)	Hep B	<input type="checkbox"/> YES ()		<input type="checkbox"/> NO
	Hep C	<input type="checkbox"/> YES ()		<input type="checkbox"/> NO
	Other	<input type="checkbox"/> YES ()		<input type="checkbox"/> NO
	(If Yes, about when)			
Medication (藥劑)				
Medication p.o. (口服藥劑)				
Intradialytic Medications(透析中的藥劑)				
()	Dose/用藥量 ()	Frequency/頻率()		
()	Dose/用藥量 ()	Frequency/頻率()		
Erythropoietin	Dose/用藥量 ()	Frequency/頻率()		
Physician Summary (醫師意見)				
※Reports on physical and mental conditions, electrocardiograms and X-rays if necessary				
ECG				
CHEST X-RAY				
CTR				
Mobility(移動)	<input type="checkbox"/> Ambulatory(自立步行) <input type="checkbox"/> Ambulatory with assist(輔助步行) <input type="checkbox"/> Wheel Chair(輪椅)			
Special Instructions (特別指示)				
※Also specify if special measures are required.				

Hemodialysis Summary(血液透析條件)				
Initial Dialysis Date (開始透析日期)	Day(日) /		Month(月) / Year(年)	
Dialysis Time (透析時間)	HRS		Frequency of Dialysis (每星期透析次數)	/week
Type of Dialysis (透析類型)	<input type="checkbox"/> HD <input type="checkbox"/> HDF <input type="checkbox"/> Other()			
product name of Dialyser (透析器)				
Surface Area (膜面積)	M^2		Blood Access(血管通路) <input type="checkbox"/> AVG <input type="checkbox"/> AVF <input type="checkbox"/> Subcutaneously fixed superficial artery(留置導管) <input type="checkbox"/> R Arm <input type="checkbox"/> L Arm  <input type="checkbox"/> Others Methods of Hemostasis(止血方法)	
Blood Flow (血流量)	ml/min			
Type of Needle (針型)				
Venous outlet pressure (靜脈壓)	mmHg			
Dry Weight (乾體重)	Kg			
Interdialysis weight gain (體重增加)	Kg			
BP (血壓)	Pre	mmHg		
	Post	mmHg		
Usual UFR (超濾速率)	ml/h			
Usual TMP (膜間壓力差)	mm/Hg			
Dialysate (透析液)				
	產品名稱			
Na+ :	K+ :	Ca++ :	Mg++ :	(mEq/L)
Bicarbonate	(mEq/L)		Glucose	(mg/dL)
Heparin	Initial Dose (開始投放量)	u		
	Maintenance (間隔)	u/H		
	Time off (結束時間)	min. before HD closing time		
Others	Initial Dose (開始投放量)	u		
	Maintenance (間隔)	u/H		
	Time off (結束時間)	min. before HD closing time		
Respose to Drop in Blood Pressure (血壓降低時的應對)	<input type="checkbox"/> Stop fluid removal(停止脫水量) <input type="checkbox"/> Raise Legs(抬起下肢) <input type="checkbox"/> Use vasopressor (使用升壓藥) <input type="checkbox"/> Reinfusion of Saline solution(注入鹽水) <input type="checkbox"/> Others: ()			

Laboratory Data (検査資料)				
Blood Type	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> AB			Rh: <input type="checkbox"/> (+) <input type="checkbox"/> (-)
Items	Results	Standard Level (標準値)	Unit	Date Day / Month / Year
BUN			mg/dl	/ /
Creatinine			mg/dl	/ /
Sodium(Na)			mEq/l	/ /
Postassium(K)			mg/dl	/ /
Chlorode(Cl)			mEq/l	/ /
Calcium(Ca)			mg/dl	/ /
Phosphorus(iP)			mg/dl	/ /
Albumen(ALB)			g/dl	/ /
AST(GOT)			IU/L	/ /
ALT(GPT)			IU/L	/ /
WBC Count			10 ³ /uL	/ /
RBC Count			10 ⁶ /uL	/ /
Hemoglobin			g/dl	/ /
Hematocrit			%	/ /
PLT Count			10 ³ /uL	/ /
HBsAg	<input type="checkbox"/> (+)	<input type="checkbox"/> (-)		/ /
HBsAb	<input type="checkbox"/> (+)	<input type="checkbox"/> (-)		/ /
HIV	<input type="checkbox"/> (+)	<input type="checkbox"/> (-)		/ /
HCV	<input type="checkbox"/> (+)	<input type="checkbox"/> (-)		/ /
RPR Test	<input type="checkbox"/> (+)	<input type="checkbox"/> (-)		/ /
VDRL	<input type="checkbox"/> (+)	<input type="checkbox"/> (-)		/ /

please either fill out the form or send blood test result sheet with the information for the above tests.

please send the result of the tests that must be performed within three months of the planned date for the dialysis.

Referring Dialysis Unit Information(貴院資料)			
Referring M.D. (主治醫生姓名)			
Hospital (貴院名)			
Address (住址)			
Phone		Fax	
I authorize the patient to receive trasient dialysis in Japan, as physician in charge, and send this patient information sheet. Date: _____ Physician's Signature(簽名) _____			

Email	info@shimada-hp.jp	Fax	+81-96-324-5190
The information contained on this sheet will be used for the sole purpose of reception checks at the facility the patient booked to have the dialysis and for the dialysis. The sheet will not be used for any other use beyond the stated purpose. Please make sure that the email address where you are sending your documents is correct. We are not responsible for any problems as a result of inadvertent transmission of your documents through email.			

