In ……
On ……..

Dear Sir or Madam

Your patient, M…… …… would like to receive care in our dialysis unit in …….. for the period running **from** …… **to** …….

Please find attached the documents to fill-in and return to us in order to best process this request:

- Our "vacationer" package to be filled-in (Don't forget to attach the documents!).
- The medical certificate to be signed by the nephrologist authorizing dialysis in our Dialysis Unit (**mandatory document for care**).
- The list of dialyzers available in our units.
  If this list does not include your patient's usual dialyzer, we ask that you please **specify your dialyzer choice** for the vacation period in our Unit.
- For admission to the first dialysis session, your patient must have a document proving his or her identity.
-

Sincerely,

Signatory / Person responsible follow-up:
Mr. ☐ Mrs. ☐……
Position
Secretary ☐ Nurse ☐

Please return the duly completed package to
secvacances.lourdes@aair-dialyse.com or by fax: +33 (0)5 62 94 19 90

For any additional questions, you may call us at: 00 33 (0) 5 62 94 26 25

AAIR MIDI PYRENÉES VACATION PACKAGE

MEDICAL RECORD

Usual dialysis center	
Address :	**Phone :**
EMail :	**Fax :**

PATIENT

LAST NAME:	First Name:

TREATMENT MODE (attached – standard certificate to be filled-in by the nephrologist)	☐ HOME ☐ SATELLITE DIALYSIS UNIT ☐ DIALYSIS CENTER
Date of last dialysis *at your usual center*	
Date of first dialysis at our site	
Date of last dialysis at our site	
Date of return dialysis *at your usual center*	

DIALYSIS PROTOCOL

Session duration/ …..:….	Rhythm/week ……/WK
Usual dialysis days	Monday / Wednesday / Friday ☐ Tuesday / Thursday / Saturday ☐
Usual dialyzer	
Nephrologist's choice (list of available AAIR dialyzers attached)	

Dialysis bath ☐ Acetate ☐ Bicarbonate mmol/l

Na: mmol/l	K: mmol/l	Ca: mmol/l	Glucose: g/l

Anticoagulation

☐ **Unfractionated heparin** Brand:
Loading dose (UI) Dose/hour (UI)
☐ **LMWH** Brand: Dose/session

Base weight: **Weight gain**

Blood pressure before HD After HD

EPO TREATMENT	☐ Yes (Date of last injection)	☐ no
EPO TYPE	Dosage (UI)	Frequency
IRON TREATMENT	☐ Yes (Date of last injection)	☐ no
IRON TYPE	Dosage	Frequency

MEDICAL RECORD

VASCULAR ACCESS

☐ AVF Type…… Arm : Right ☐ Left☐
☐ Synthetic material or graft
☐ Two Needles ☐Single Needle

Needles N° Arterial : …… Venous : ……

☐ Catheter Double lumen ☐ Catheter Single lumen

Type of locking……
Art lumen ……ml Venous lumen……ml

Blood pump rate		Arterial pressure		Venous pressure	

Etiology of renal deficiency

Antecedents and summary / Illness history to be attached

MEDICAL ISSUES – ALLERGIES

MEDICAL TREATMENTS

BLOOD GROUP

(Attach photocopies of 2 determinations)

SEROLOGICAL STATUS (tested < 3 months)					Test date
HBV	HBs Ag		Anti-HBs Ab		
HCV			PCR C		
HIV					

Transplant - On waiting list:	☐ **Yes**	☐ **No**
Transplant Center (address and telephone)		

SPECIAL MONITORING

SELF SUFFICIENT'S FORM PATIENT

Mobility	☐ Self sufficient	☐ With Help	☐ Wheelchair / Stretcher
Clothing	☐ Self sufficient	☐ With Help	☐ No
Weighting	☐ Self sufficient	☐ With Help	☐ No
Compression	☐ Self sufficient	☐ With Help	☐ No
Fooding	☐ Self sufficient	☐ With Help	☐ No
Weight gain	☐ Normal	☐ Variable	☐ Always High

Must Attach (if not filled-in on the medical record)
Antecedents and/or history of the illness, Medical treatment, Complete laboratory work-up (-3 months)
Viral serology (-3 months)

Date :
Nephrologist's Signature

MEDICAL CERTIFICATE

I, the undersigned, Dr. ……., hereby certify that
M…… 's health allows for Artificial Kidney treatment:

❑ At the Satellite Unit dialysis (with nurses only during the session but the doctor can be always joined)

belonging to AAIR MIDI PYRENÉES

❑ Exclusively at a dialysis center

Certificate drawn-up to serve and avail when and where required.

Date :
Nephrologist's Stamp & Signature

PATIENT CONSENT

I, the undersigned, Mrs., Mr. ……..……..
hereby state, after being informed of the various treatment methods by extra-renal purification, that I willingly accept

❑ treatment by **replacement hemodialysis**:

- ❑ At a Satellite Unit dialysis
- ❑ At a dialysis center

I hereby confirm all the administrative and medical information about me and I authorize any additional medical exams required for my medical follow-up, including viral serology monitoring (Hepatitis B-C, HIV...)

Date :
Patient's signature preceded by the handwritten acknowledgment « read and approved »

Pharmacy Department:
✆ +33 (0)5 61 16 14 50 - 🖷 +3 (0)5 61 31 06 82
e-mail: pharmacie-technique@aair-dialyse.com

AAIR MIDI PYRENEES VACATION PACKAGE

Dialyzer List

Dénomination	Membrane	Steril.	Surf m²	UF
BG-1.8U,FILTRYSER, TORAY	PMMA	Gamma	1,8	35
BG-2.1U,TORAY	PMMA	Gamma	2,1	43
ELISIO 17H, NIPRO	Polynephtron	Gamma	1,7	74
ELISIO 21H, NIPRO	Polynephtron	Gamma	2,1	82
ELISIO 25H, NIPRO	Polynephtron	Gamma	2,5	93
EVODIAL 1.6, HOSPAL	AN 69	Gamma	1,6	50
FDX 180 GW,NIKKISO	PEPA	Gamma	1,8	57
LEOCEED 18H, ASAHI	Polysulfone	Gamma	1,8	76
LEOCEED 21H, ASAHI	Polysulfone	Gamma	2,1	88
PHYLTHER HF 17 SD, BELLCO	Polyphénylène	Vapeur	1,7	53
REVACLEAR 400	PAES/PVP	Vapeur	1,8	54
TORAYLIGHT NS-21S,TORAY	Polysulfone	Gamma	2,1	53

AAIR MIDI PYRENEES VACATION PACKAGE

ADMINISTRATIVE DATA SHEET

LAST NAME ……

FIRST NAME ……

Birth Name ……

BIRTH DATE /__/__/__/__/__/__/__/__/

ADDRESS ----------

Home Phone /__/__/__/__/__/__/__/__/__/__/ **Cell Phone** /__/__/__/__/__/__/__/__/__/__/

VACATION ADDRESS	**PHONE** (vacation site)

Date of arrival on vacation site	**Time**	**Means of transport** ☐ **Personal car** ☐ **Train** ☐ **Plane** ☐ **Bus**
Date of departure	**Time**	**Means of transport** ☐ **Personal car** ☐ **Train** ☐ **Plane** ☐ **Bus**

Must attach
*- A **LEGIBLE** copy of your identity papers (or passport) front & back*

For European Union patients:

*- A Valid **European Health Insurance Card** (or certificate) or original of form E111 or E112.*
*All these documents must be perfectly **LEGIBLE.***

A.A.I.R. Midi Pyrénées	PATIENT'S LEGAL REPRESENTATIVE DESIGNATION FORM	Ref.: Version:
Application date: Feb. 3rd, 2010		

PATIENT LABEL

PATIENT'S LEGAL REPRESENTATIVE DESIGNATION

(Article L 1111-6 of the French Public Health Code)

YES ❑ NO ❑

All adult persons may designate a legal representative who may be a family member, relation, or attending physician who will be consulted if said person is unable to express his or her will and receive all information required for that purpose.
Such designation must be made in writing.

I the undersigned:
☐ Mrs. ☐ Miss ☐ Mr.
Married **Name**: …… Maiden **Name**:……..
Given Names:……
Date and Place of Birth:……..
Address:…….
TELEPHONE(S): …….
Admitted to AAIR as of:……

☐ does not wish to designate a legal representative

☐ would like to designate as ***legal representative***::

☐ Mrs. ☐ Miss ☐ Mr.
Married **Name**: …… Maiden **Name**:……..
Given Names:……
Date and Place of Birth:……..
Address:…….
TELEPHONE(S): …….

Said legally capable legal representative is:

☐ A family member ☐ A relation ☐ My attending physician

I hereby acknowledge having been informed of the option available to me to designate a legal representative or not for the length of my stay. I may revoke this designation at any time and in such case, I shall inform the establishment in writing by filling out the designation form.

Date Signature

Section reserved for the legal representative

I hereby accept being Mrs., Miss, Mr.……**'s legal representative and to be consulted if said person is unable to express his or her will and receive any information required for that purpose. I have been informed that such designation may be revoked at any time by the patient.**

Date Signature