

INITIAL DIALYSIS REGISTRATION

Dear Patient,

To ensure that we can schedule you smoothly as a new dialysis patient, please do the following:

1. Please send us in advance:

- Dialysis regimen (including dialysis parameters, hepatitis and HIV serology no more than one year old, previous diagnoses, and current medication plan) from your previous dialysis center or hospital
- Most recent hospital discharge letter
- This completed questionnaire

2. Please bring to your first dialysis session:

- Your health insurance card and, if applicable, proof of exemption from co-payments
- If applicable, referral form from your previous dialysis center
- If applicable, proof of care level (see below)
- If applicable, proof of disability codes (see below)
- If applicable, advance healthcare directive/power of attorney (see below)

Which location would you like to register for? Please tick the appropriate box	
☐	☐
Weimar location	Apolda location
Nephrology practice and dialysis center Henry-van-de-Velde-Str. 1 99425 Weimar	Nephrology branch practice and dialysis center Jenaer Str. 66 99510 Apolda
Dialysis hours	Dialysis hours



Monday to Saturday 6.30 – 17.30 Uhr	Monday / Wednesday / Friday 6.30 – 22.30 Uhr
Consultation hours	Consultation hours
Monday 8.00 – 13.00 and 15.00 – 17.00	Monday 8.00 – 13.00 Uhr
Tuesday 8.00 – 13.00 Uhr	Wednesday 8.00 – 13.00 Uhr
Wednesday 8.00 – 13.00 Uhr	Friday 8.00 – 11.00 Uhr
Thursday 8.00 – 13.00 Uhr	
Friday 8.00 – 11.00 Uhr	
Contact	Contact
Tel.: 03643 59619	Tel.: 03644 516805
Fax: 03643 510025	Fax: 03644 516813

Personal details

Name	
Date of birth	
Telephone	
Email	
Street	
Town/city, postal code	

Which dialysis center previously cared for you? / At which hospital did you previously receive dialysis?

Name	
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Address	
Telephone	
Attending physician	
Comments	
When would you like to start dialysis with us?	
Start date	

How will you travel to our dialysis center? Driving yourself or by taxi? (We are happy to help you find a suitable taxi company.)

How mobile are you? Do you require a wheelchair, walking frame, etc.?

Are you able to transfer independently, for example from a wheelchair to a bed?

Do you have any infectious diseases (e.g. MRSA, VRE, hepatitis)?
If so, which?



Do you have any allergies or medication intolerances?

List of allergies

Are there any other special considerations we need to know about for your dialysis?

Which relative may we provide with information (release from medical confidentiality)?

Name

Relationship

Telephone

Are there any other carers or legal representatives whom we may provide with information (release from medical confidentiality)?

Name

Relationship

Telephone

Do you have a disability ID card/severely disabled person's ID card?

Yes

☐

No

☐

Which disability codes are listed? (Please bring the document for copying.)

Disability codes



Do you have an officially assessed care level? If so, which? (Please bring the document for copying.)

Care level

Do you receive support from a home care service?

Name

Address

Telephone
number

Do you have a power of attorney for healthcare, an advance healthcare directive, or a legal guardianship certificate? (Please bring the document for copying.)

Yes

☐

No

☐

By signing below, I confirm that I have understood the questions, have been adequately informed about the matters listed, and have been given sufficient time to consider them. I may revoke any declarations I have made at any time without giving reasons.

Place, date

Signature