Turkish Kidney Foundation

Ahmet Ermis Dialysis Center

Transient Transfer Form

Patient Name :……

Date of Birth :……. **Age:**……..

Home Address:……..

Home Phone :……

Cell Phone :……

Referring Physician: …….

Adress While Visiting In Area: ……..

……

Local Phone Number : ……..

Desired Dates For Treatment:…….

Medical History

Primary Diagnosis : ……..

Secondary Diagnosis : ……..

Any Known Medical Problems: ……

……..

Known Allergies: ……..

Blood Type: ……..

Date of Last Transfusion: …….

Dialysis

Date of Initial Treatment: ……

Frequency of Dialysis/Week: ……..

Duration of Treatment: …….

Average Blood Flow: ……

Dialyzer: …….