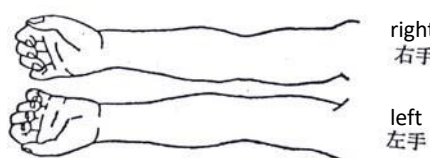


# Temporary Dialysis Request Form

Please fill out the request form by a doctor or medical professional except in case of a disaster.

Medical Corporation Ken'aikai Akiyama Clinic  
TEL:+81-087-815-8588 FAX:+81-087-815-8688

Facility name		Phone		
		FAX		
Country		Date of birth	age	Male • Female
Patient's name				
Dialysis request date		infectious disease	HBs (    ) HCV (    ) Syphilis (    ) HIV (    ) Others	
The original disease		blood type	TYPE	RH (    )
complication		Dialysis time		
Number of dialysis	times / week	Anticoagulants	Anticoagulant name	
			first time	U/h
			continuation	U/h
Blood flow	ml/min.	Body weight	kg	
Puncture site	Blood access (internal shunts and artificial blood vessels)   <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>right 右手</span> <span>left 左手</span> </div>	Dializer		
		Cardiothoracic ratio	% (date    )	
		Drug contraindications		
Regular injections				
Regular medicines				
Precautions during dialysis				

Filler

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