

MEDICAL QUESTIONNAIRE 透析患者質問書

Please fill in English (全て英語でご記入お願いいたします)

Patient Information (患者情報)

Name (名前)		
Date of birth (生年月日)	(YYYY/MM/DD)	
Age (年齢)		
Sex (性別)		
Blood type (血液型)		
Country (国籍)		
Address (住所)		
Phone number (電話番号)		
Emergency contact person (緊急連絡先)	Name (名前)	
	Phone number (電話番号)	

Medical history (病歴)

Drug allergies (薬物アレルギー)	<input type="checkbox"/> No		
	<input type="checkbox"/> Yes		
History of clinical hepatitis (肝炎 有無)	Hep. B:	No	
		Yes	
	Hep. C:	No	
		Yes	
Etiology of chronic renal failure (慢性腎不全の病因)			

◎Schedule (スケジュール)

Visiting date (旅行期間)	From	(YYYY/MM/DD)
	To	(YYYY/MM/DD)
Requested date (透析希望日時)	1	(YYYY/MM/DD)
	2	(YYYY/DD/MM)
	3	(YYYY/DD/MM)
Hotel name (ご滞在先, ホテル名)		
Hotel phone number (ご滞在の電話番号)		

Dialysis Treatment (透析治療)

<input type="checkbox"/> HD (血液透析) <input type="checkbox"/> HDF (血液濾過透析) <input type="checkbox"/> other (その他)	
Type of replacement fluid (置換液のタイプ - HDF)	
Type of dialyser (ダイアライザー名)	
Surface area (表面的)	
Type of vascular access (血管アクセスの種類)	
Vascular access site (透析血管の位置)	
Type of needle / Size (針のタイプ / サイズ)	/
Note (注意事項)	

Date of dialysis treatment for the first time (透析開始日)	(YYYY/MM/DD)
Dialysis treatment per one time (1回の透析時間)	Hours
Number of sessions per week (透析回数 / 週)	/week (週)
Last scheduled dialysis date before the requested date(希望透析日直前の透析日)	(YYYY/MM/DD)
Venous outlet pressure range (静脈側圧)	mmHg
Usual water removal rate (1時間当たりの除水量)	ml/hr
Blood flow (動脈側流量)	ml/min
Dialysate flow (透析液流量)	ml/min

Weight (体重)	Dry weight (ドライウェイト)	kg
	Average weight gain (平均体重増加)	kg

Blood pressure (血圧)	Pre-dialysis (透析前)	mmHg
	Post-dialysis (透析後)	mmHg

Erythropoiesis stimulating agent (ESA)	<input type="checkbox"/> required	<input type="checkbox"/> not required
type of ESA (ESAの種類)		
Dose (容量) / Cycle (サイクル)		
Administration (投与方法)	<input type="checkbox"/> Subcutaneous	<input type="checkbox"/> Intravenous

Anticoagulant (抗凝固剤)	<input type="checkbox"/> Heparin sodium	<input type="checkbox"/> Dalteparin sodium	<input type="checkbox"/> Nafamostat mesilate	<input type="checkbox"/> not required
Applied dose (容量)	initial dose			
	Hourly dose			
	time off			

/hour (/時)

LABORATORY DATA (検査結果)

Lab Test (検査項目)	Date (検査日)	Result (結果値)	
Hemoglobin			g/dl
Hematocrit			%
BUN (Blood urea nitrogen)			mg/dl
Creatinine			mg/dl
Potassium			mEq/L
Calcium			mg/dl
Phosphate			mg/dl
AST			IU/L
ALT			IU/L

Please enclose laboratory copy. (次の項目について血液検査結果用紙を添付してください)

(Within 3 months valid date)

1. HBs Ag / Ab 2. HCV 3. HIV 4. VDRL

ECG(Electrocardiogram)	
Date of examination	(YYYY/MM/DD)
Chest X-ray	
Date of examination	(YYYY/MM/DD)
CTR(Cardio thoracic ratio) (心胸比)	%

Medications list (飲み薬)

Active ingredient (成分名)	Brand name (商品名)	Quantity (用法, 用量)

Note: Please bring your own supply of oral medication(s) (注意 : 常用中のお薬はご持参してください。)

Special Instructions (特別指示)	
Possible problems during session (透析中の問題)	
Medications during or at the end of session (透析中、透析後に服用する薬)	

REFERRING DIALYSIS UNIT INFORMATION (紹介担当医)

Referring M.D. (担当医)	
Referring hospital (病院名)	
Phone number (病院の電話番号)	
Address (住所)	
Date (日付)	
Agreement (旅行透析同意書)	<p>I certify that the information given regarding _____ (patient's name) is correct and permission is granted by _____ (physician's name)</p>
Physician's Signature (担当医 署名)	