NATIONAL KIDNEY FOUNDATION OF SAMOA

(Established: National Kidney Foundation of Samoa Act 2005)

PO Box 611
Motootua,
Samoa

Tel: (685) 32-123 / 32120
Tel: (685) 32-231 /32-240
Website: www.nkfs.ws

APPLICATION FOR HOLIDAY DIALYSIS

To ensure that we are able to provide you with the best care through a safe and efficient ***'holiday'*** dialysis, please read the following carefully and provide all necessary documents.

1. Please submit this form together with all attachments (see checklist on page 3) to chris@nkfs.ws and copy to alogai@nkfs.ws and fnauer@nkfs.ws at least 4 weeks prior to arrival
2. Hemodialysis date(s) and time(s) will only be confirmed when all the correctly completed health information is received. If application is approved, you will be advised of your proposed schedule in accordance to unit availability.
3. **Holiday dialysis fees from the 01st September 2023,**
    1. Non Samoan - SAT1,000.00 per session
    2. Samoans whose main residence is NOT Samoa - SAT600.00 per session
    3. For a Samoan who wishes to return to live permanently in Samoa
        a. SAT600.00 per treatment for the first 6 consecutive sessions; then
        b. Reduce to SAT300.00 per treatment for the next 12 consecutive sessions;
        c. Eligible for the local fee after satisfying 1 and 2 above
        d. Live in Samoa permanently for at least 1 year before relocating overseas
    4. A penalty rate of SAT$100.00 on top of normal holiday rate should a patient turn up without prior approval from NKFS
    5. Advance payment is always required before dialysis sessions. We will forward bank account details once application is approved.

APPLICANT INFORMATION

(Mr/Mdm/Mrs/Miss) LAST NAME: ______________________________

FIRST NAME: ______________________ DATE OF BIRTH: ______________

GENDER: FEMALE / MALE NATIONALITY: __________ PASSPORT NO: ______________

CONTACT NO: (   ) - ______________ EMAIL ADDRESS: ______________

HOME ADDRESS: ______________________________

COUNTRY: ______________________ **Referral Unit Name:** ______________

CONTACT PERSON & ADDRESS IN SAMOA: ______________________________

CONTACT NO: (   ) - ______________ EMAIL ADDRESS: ______________

CONTACT PERSON FOR CLINICAL INFORMATION AT REFERRING UNIT: ______________

Designation: __________ CONTACT NO: (   ) - __________ Email ______________

DATE OF LAST HD AT HOME BEFORE TRAVELLING TO SAMOA: ________ / ________ / ________
(DAY / MONTH/ YEAR)

DATE OF ARRIVAL IN SAMOA: ______ / ______ / ______ *DATE OF DEPARTURE:* ______ / ______ / ______
(DAY/ MONTH/ YEAR) *(DAY/ MONTH/ YEAR)*

NO. OF SESSION(S) NEEDED: ________ FROM / ON: ______________ TO: ______________
(DAY/MONTH/YEAR) *(DAY/MONTH/YEAR)*

**Charges quoted does not include costs of Medication*

REFERRING PHYSICIAN

APPLICANT'S MEDICAL HISTORY (TO BE COMPLETED BY REFERRING DOCTOR)

(Please attach certified medical reports, blood tests result and heart report)

PHYSICIAN'S NAME: ________________________________ DIALYSIS UNIT NAME: ________________________________

Email: ______________________________ CONTACT NO: (   ) _________________________________

NAME OF APPLICANT: ____

PRIMARY DIAGNOSIS: ____

CO-MORBID CONDITIONS: ____

FORM OF ACCESS: __________________ **BLOOD FLOW RATE**: ___________**STATUS**: _________________________

FUNCTIONAL STATUS OF AV FISTULA _____________________________ **NEEDLE SIZE**: ________________________

Pre-cannulation local anesthetic is not offered

ACETATE/BICARBONATE DIALYSIS *(please circle)* **FREQUENCY OF DIALYSIS PER WEEK**: __________________

HEPARIN DOSAGE: ______________________ **TYPE OF DIALYSER**: ______________________________

NO OF DIALYSIS HOURS: _______________________ **DRY WEIGHT**: _____________________________________

MEDICATIONS APPLICANT IS CURRENTLY ON (Dosage & Frequency): __________________________________

____

____

ALLERGIES/ ADVERSE REACTIONS: ____

____

DIALYSIS INDUCED SYMPTOMS : NEVER / RARELY / COMMONLY

HEPATITIS B S ANTIGEN : POSITIVE / NEGATIVE **(Please provide certified report)**

HEPATITIS C ANTIBODY : POSITIVE / NEGATIVE **(Please provide certified report)**

HIV STATUS (COMPULSORY) : POSITIVE / NEGATIVE **(Please provide certified report)**

A CERTIFIED RECENT (ONE MONTH) COPY OF THE LABORATORY RESULTS FOR MRSA, VRE, AND ESBL; BIOCHEMISTRY; HAEMATOLOGY MUST BE SUBMITTED FOR THE APPLICATION TO BE PROCESSED

ANY INFECTIOUS DISEASE/S : NO / YES *(please list below)*
TREATMENT: ____

HEART DISEASE : NO / YES *(please list below)*
(pls provide scan report if any was done) *TREATMENT:* ____

RECENT ECG STATUS : ____

DIABETES : NO / YES *(please fill in below)*
TREATMENT: ____

MENTAL ILLNESS : NO / YES

____ _______________________

PHYSICIAN'S NAME AND SIGNATURE **DATE**

HOLIDAY DIALYSIS INFORMATION CHECKLIST

*Please check if you have all the necessary documents attached.
(All blood results must be recent (not more than one month old)

Copy of Passport	Yes / No
Hepatitis B Result	Yes / No
Hepatitis C Result	Yes / No
HIV Result	Yes / No
ESBL Result	Yes / No
MRSA Result	Yes / No
VRE Result	Yes / No
ECG	Yes / No
Hematology Result	Yes / No
Biochemistry Result	Yes / No
Dialysis Prescription	Yes / No
Dialysis Report (last three dialysis)	Yes / No
Medical Letter	Yes / No
Medication List	Yes / No