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
        e. Must have a permanent form of access (AVF) prior to returning and can not be transferred permanently with a Tunneled line/Temp line unless an AVF is not possible (report from Vasc surgeon)
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)*

For returning residents- Date of commencement of dialysis- _____/_____/_____

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 echo report if any cardiac history)*
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 ***(Nephrologist Recent Review/summary-required)***	**Yes / No**
Medication List	Yes / No
For returning Citizens- *Medical records from GP and last 2 yrs records from hospital (admissions/Discharge summaries and laboratory results)*	Yes / No