239 Western Main Road,
Cocorite, Trinidad & Tobago
Tel: (868) 622-2025 / 6528

Welcome to CARIBBEAN KIDNEY & DIALYSIS INSTITUTE LIMITED.
Please read the following and fill out the necessary information.

Your Social Worker or Holiday Coordinators can assist you with this. If you have any disabilities or special needs, please remember to mention them. Our dialysis machines are Fresenius 2008K with a state-of-the-art water treatment system. Our water quality exceeds those recommended by international standards (AAMI and CDC). Optiflux dialysers are used at this clinic. If you require a specific dialyser, we ask that you bring your own. You are also required to bring your own medication. Remember to transport your erythropoietin in a cool container and we shall be happy to store it for you during your stay.

The following must be emailed one month prior to traveling in order to facilitate your treatment:

- Laboratory copies of HIV, Hepatitis B & C and MRSA screens
- A drug prescription signed by your doctor.
- A letter from your doctor confirming you are fit for travel and holiday dialysis.
- Copies of your last three (3) dialysis flow sheets.

Please contact us should you have any queries. Do not hesitate to ask if there is anything else that you would like us to do in order to make your stay a pleasant one.

Tel/Fax: 1-868-622-2025 or 868-622-6528
Email: info@ckditt.com

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Information form

Client's name: ____________________ **Date of Birth:** DD / MM / YY

Home Address: ____________________

Country ____________________

Tel: ____________________ **E-mail:** ____________________

Your Dialysis Clinic Name ____________________

Your Dialysis Clinic Address ____________________

Tel: ____________________ **Fax:** ____________________

Next of Kin's name: ____________________

Contact number: ____________________

Address in Trinidad: ____________________

		DD / MM / YY		
HIV:	Date of last test:	/ /	Result:	
MRSA:	Date of last screen:	/ /	Result:	
Hepatitis B:	Date of last test:	/ /	Result:	
Hepatitis C:	Date of last test:	/ /	Result:	
Chest X-ray:	Date of last test:	/ /	Result:	

I hereby certify that the above information is correct.

Name: ____________________

Date: ____________________ Position: ____________________

Please remember to fax copies of the laboratory results with this form. This form must be returned at least 4 weeks prior to travel

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Dialysis Prescription

Client's Name: ☐

Dialysis Frequency: ☐ /week **Duration:** ☐ hours

Dry Weight: ☐ **Average weight gain:** ☐

Access: ☐ fistula ☐ gortex ☐ permcath

Permcath Lock (mls): ☐ Arterial ☐ Venous

Heparin: ☐ 25,000uts ☐ 5,000uts ☐ Using Citralock 30%

Needle size: ☐

Average blood flow rate: ☐ **Average venous pressure:** ☐

Heparin loading dose: ☐ **Maintenance Heparin:** ☐

Any Access Problems: ☐

Allergies/problems with lignocaine: ☐

Any problems on dialysis: ☐

Any other problems: ☐

Medications post-dialysis: ☐

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Dialysis Dates

Client's name: ____________________

		DD		MM		YY		DD		MM		YY
Duration of Holiday:	**From**		/		/		**To**		/		/	

		DD		MM		YY	DD		MM		YY
Preferred Days For Dialysis	**From**		/		/			/		/	
			/		/			/		/	
			/		/			/		/	
			/		/			/		/	
			/		/			/		/	

Preferred Time For Dialysis ____________________

____

This form must be returned at least 4 week prior to travel.