January 1, 2016

1849 YONGE ST. Suite 418 TORONTO, ONTARIO, CANADA M4S 1Y2 PHONE # 416-545-1090 FAX # 416-545-1091
E-mail 1: **jbianchi@bell.net** E-mail 2: **igal@idirect.com**

TRAVELLERS

WELCOME TO TORONTO, ONTARIO, CANADA

GENERAL INFORMATION:
We have provided haemodialysis to the travelling patient since 1982. As we are not open at all times our answering service is available 24 hours per day. Please leave your name and a phone or fax number or your mailing address and we will return your call or get an information package to you.

TREATMENTS:
WE DO NOT ACCEPT HEPATITIS B ANTIGEN OR MRSA/VRE POSITIVE PATIENTS.
Maximum treatment time is 4 hours (less as required).
Scheduling will be according to your requirements but is subject to change depending on other travellers and staff availability.
You may be examined by our Medical Director or associate during your stay with us and they will be available to you on non-dialysis days.
Please confirm your arrival 48 hours prior to your scheduled treatment.

MEDICATION:
Medications are **NOT PROVIDED**. Please bring your daily requirement of medication with you.
Post dialysis intravenous infusion of medication is not given except EPO and Calcijex.
EPO AND CALCIJEX ARE NOT PROVIDED. BRING THE REQUIRED DAILY DOSE FOR US TO ADMINISTER.

FOOD:
Hot and cold beverages are provided. You are welcome to bring a packed meal.

ENVIRONMENT:
Relatives and friends are permitted to visit.
Radio, TV and telephone are available. Long distance calls must be made collect.
We are located in a non-smoking building.

SPECIAL NOTE:
Travellers have arrived to our facility with high pre dialysis potassium. We may take chemistries on the first dialysis and once a week depending on the length of your stay. Our Medical Director will recommend medication or changes in treatment based on the results.

The cost of the blood tests is in addition to the dialysis fees. We will inform you of this cost.

Please note that the main door to the building opens at 7:00 AM Monday through Friday and at 8:00 AM on Saturdays. There is a directory and a phone to the side entrance of the building from which you can call the unit and the nurse will open the door for you if you find it locked.

We hope you enjoy your stay with us and have a pleasant trip to Toronto.

FEE SCHEDULE

The cost per treatment is $575.00 (CAN. dollars) for four hours or less. It is $675.00 for five hours.

A deposit of $100.00 is required to book a treatment. If you cancel your treatment prior to 48 hours before the first scheduled dialysis your deposit will be refunded. An administrative fee of $25.00 will be retained from your deposit.

TREATMENT NO REFUND WILL BE ISSUED.

FULL PAYMENT IS DUE PRIOR TO THE START OF EACH TREATMENT.

Due to the numerous problems we have encountered with personal cheques, we accept only CASH, MONEY ORDER or CERTIFIED CHEQUE. **We do not direct bill due to past issues with collection.**

Canadian provincial health insurance may cover some of the costs. We recommend that you check with your insurance provider regarding payments for dialysis and the required documentation. Speak to the nurse at DSI for further information.

Blood tests may be taken but are not included in the above costs. You will be informed of the cost that will be added to your bill.

Receipts will be issued on your last treatment. These receipts can be used to obtain a refund from the insurance provider.

Any unforeseen medical problems will be your financial responsibility.

NO DIALYSIS WILL BE BOOKED IF YOU DO NOT RECONFIRM YOUR ARRIVAL 48 HOURS BEFORE THE FIRST REQUESTED TREATMENT. If you show up without prior re-confirmation you may need to wait for the next available spot for a dialysis treatment.

INFORMATION LIST:

The enclosed forms should be completed and along with the requested reports, returned to us at least 2 weeks prior to your first required treatment.

Incomplete information could result in a delay, a change or no confirmation in the scheduled treatments.

Please make copies of all this requested information. Mail or fax one copy at least 2 weeks prior to arrival in Toronto. The second set should then accompany the patient as mail has been lost.

Use the list as a reminder that all information requested has been included in your package.

Medical information sheet (our forms completed and **page 6 signed by the referring physician**)

Consent Form (enclosed) _____

3 recent dialysis flow sheets (to be sent with your request) _____
(Bring the last 3 most recent dialysis flow sheets on your First treatment with us)

Recent ECG report (recommended within 1 yr) _____

Recent X-ray report (recommended within 1 yr) _____

Recent History and Physical report _____

Recent Pre and Post dialysis chemistries _____

HBsAg and HBsAb reports _____

Deposit - $100.00 (CAN) _____

PHONE NUMBER IN THE LOCAL AREA _____

CONTACT IN THE AREA _____

PATIENT CONSENT

1. I have been fully informed by my referring physician (nephrologist) of the surgical and medical procedures and the problems and risks involved with haemodialysis.

2. I hereby authorize and direct DR. M. GOLDSTEIN, medical director of Dialysis Services Inc., and/or assistants or associates of his choice to perform upon me haemodialysis and/or any other therapeutic procedures that their judgement may dictate to be advisable for my health and wellbeing.

3. I understand that Dialysis Services Inc. is an outpatient facility and serves only patients deemed fit to dialyze in an out of hospital setting. In the event that I am not a suitable candidate for this facility or in cases of emergency or disaster I recognize that I will be asked to return to my referring hospital or will be directed to an acute care facility.

3. This consent is for repeated haemodialysis treatment, and as such will be deemed effective for all treatments received by me unless this consent is expressly revoked by me.

4. I further understand that by granting my consent for dialysis I agree to hold and save harmless Dialysis Services Inc., its staff and associates from any liability for any complications arising from the dialysis treatment or medical conditions that may occur between dialysis.

5. I also acknowledge that my treatment schedule may be altered from time to time and that no guarantee of a schedule has been made to me.

6. I agree to pay the full amount for each treatment as set out in the forms given to me.

I acknowledge that I have read or have been read and explained the above consent and all other information regarding my dialysis treatment at Dialysis Services Inc.(also known as DSI) and agree to comply with the policies and procedures at DSI.

PATIENT SIGNATURE: _____

WITNESS: _____

DATE: _____

SIGNATURE _____
(DSI REPRESENTATIVE)

PATIENT INFORMATION

NAME:..... SEX:..... DATE OF BIRTH:.....
ADDRESS:..... PHONE #:.....
.....
.....
NEXT OF KIN:..... RELATIONSHIP:.....
ADDRESS:..... PHONE :.....
..... CONTACT PHONE # IN TORONTO.....
.....
SOCIAL INSURANCE :.....
MEDICAL INSURANCE#:..... POLICY#:.....
DIAGNOSIS:..... HEPATITIS B ANTIGEN: NEG..... POS.....
BLOOD GROUP:..... ALLERGIES:.....
MOBILITY(ambulatory, wheelchair, etc.):

DIALYSIS INFORMATION

YEARS ON HEMODIALYSIS:.....
VASCULAR ACCESS:..... FIRST USE OF VASCULAR ACCESS.....
DIALYSIS: IN CENTER:..... SELF CARE:.....HOME:.....
DIALYZER: TYPE:..... SURFACE AREA:.....
FREQUENCY OFTREATMENTS:..... DURATION:.....
AVERAGE BLOOD FLOW:..... AVERAGE VENOUS RESISTANCE:.....
HEPARIN: BOLUS (UNITS):..... HOURLY INFUSION RATE (UNITS):.....
IDEAL WEIGHT:..... AVERAGE WEIGHT GAIN:.....
COMPLICATIONS DURING DIALYSIS:

DIALYSATE (mEq/liter or Mg %)

SODIUM CHLORIDE:..... SODIUM ACETATE:.....
POTASSIUM CHLORIDE:..... SODIUM BICARBONATE:.....
CALCIUM CHLORIDE:..... DEXTROSE (GLUCOSE):.....
MAGNESIUM CHLORIDE:..... DIALYSATE FLOW RATE:.....

Sodium Ramping:..... Ultrafiltration Profiling:.....

CHEMISTRIES (most recent pre-dialysis) DATE TAKEN:

HEMOGLOBIN:.....	UREA:.....	POTASSIUM:.....
HEMATOCRIT:.....	CREATININE:.....	CALCIUM: ……
ALBUMIN: ……..		PHOSPHOROUS: ……

You can send a copy of the laboratory results instead of writing them in the above space.

PATIENT NAME:

MEDICATION (a list may be provided if computer generated instead of entering below)

NAME:	DOSE:	NAME:	DOSE:
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

OTHER INFORMATION (RELEVANT TO TREATMENT ie: heparinization of central or jugular line)

.....
.....
.....

*THE FOLLOWING IS AVAILABLE AT THE CLINIC. PLEASE HAVE THE DOCTOR CIRCLE OR CHECK OFF THE PREFERENCE FOR THE PATIENT DURING TRAVEL

BATH K: 1 2 3

Other concentrate additives are not negotiable and are as follows: Mg 0.50 mmol (1.00 mEq), Acetate 4.0 mmol(4.0 mEq), Dextrose 8.32 mmol (150 G/L), Calcium Chloride 1.25 mmol/L (2.5 mEq)

DIALYZER: the following are considered high efficiency, low to mid flux (no other types available)

POLYSULFONE: F6 (1.25 M^2) ☐ F8 (1.8 M^2) ☐ Cellulose Acetate –210 (2.1 M^2) ☐

DATE(S) REQUESTED

DAY:.....	DATE:.....	DAY:.....	DATE:.....
DAY:.....	DATE:.....	DAY:.....	DATE:.....
DAY:.....	DATE:.....	DAY:.....	DATE:.....
DAY:.....	DATE:.....	DAY:.....	DATE:.....
DAY:.....	DATE:.....	DAY:.....	DATE:.....

TYPE OF PAYMENT

CERTIFIED CHEQUE:.....	MONEY ORDER:.....	CASH:.....

REFERRING DIALYSIS FACILITY:.....

FACILITY CONTACT AND PHONE #:.....

DOCTOR:..... **PHONE NO**.:.....

(MISS, MRS., MR.)_____ is stable and fit to travel and dialyse in a non-hospital setting.

SIGNATURE:_____ M.D.