

Pre-Travel Medical Form

To be completed with your healthcare provider before traveling.

PATIENT INFORMATION

Full Name:

Date of Birth:

Home Address:

Emergency Contact Name & Phone:

DIALYSIS TREATMENT DETAILS

Type of Dialysis: Hemodialysis Peritoneal Dialysis

Dialysis Frequency: Times per week

Dialysis Duration: Hours per session

Access Type: AV Fistula Catheter PD Catheter

MEDICAL HISTORY

Relevant Medical Conditions:

Allergies:

Recent Lab Results (eg. Kt/V, potassium, henvglobin):

MEDICATIONS

MEDICATION NAME	DOSAGE	FREQUENCY

TREATING PHYSICIAN

Doctor's Name:

Clinic/Hospital:

Phone Number:

Please ensure all information is accurate and up-to-date before traveling.