

DIALYSIS INFORMATION SHEET

(Please Fill Out If It Applies)

PATIENT'S NAME: _____

DATE OF BIRTH: _____

DIALYSIS CENTER'S NAME: _____

DIALYSIS CENTER'S
PHONE NUMBER: _____

FAX NUMBER: _____

CONTACT PERSON: _____

DIALYSIS DAYS AND TIME: _____

ARE YOU RIGHT OR LEFT HANDED?

IS THE PATIENT TAKING BLOOD THINNERS?

YES

NO

IF YES, WHAT ARE THEY? _____

NAME OF NEPHROLOGIST: (Please Circle the Correct One)

Dr. Shah

Dr. Desai

Dr. Mehta

Dr. Gandhi

Dr. Abdeen

Dr. Assomull

Dr. Dua

Dr. Patak

Dr. Shook

Dr. Slavov

Dr. Nemeh

Dr. Sadeghi

Dr. Khosroabadi

Other Please List
