Republic of the Philippines
Department of Health
MARGOSATUBIG REGIONAL HOSPITAL
Margosatubig, Zamboanga del Sur

HEMODIALYSIS NOTIFICATION FORM

FAMILY NAME: _____
FIRST NAME: _____
MIDDLE NAME: _____

WARD/ ROOM: _____

Date of Birth: _____ Age/ Sex: _____ HRN: _____
Address: _____
Civil Status: _____ Religion: _____ Nationality: _____
Weight: _____ Height: _____

DIAGNOSIS/ INDICATION FOR HD: _____

VASCULAR ACCESS ☐ INTRA-JUGULAR ☐ FEMORAL ☐ PERM CATH ☐ AVF
DATE CREATED _____
HBsAg ☐ Reactive ☐ Non-Reactive Date: _____ Hemoglobin: _____ Date: _____
Anti-HCV ☐ Reactive ☐ Non-Reactive Date: _____ Available Blood Unit:

HD PRESCRIPTION

Dialyzer: _____ Blood Flow Rate: _____ Anti-coagulant: _____
Frequency: _____ Dialysis Flow Rate: _____ Dose: _____
Duration: _____ UF Goal: _____
Dialysis Bath: _____ Weight: _____

NAME OF ORDERING PHYSICIAN: _____
NOTIFIED BY: _____
RECEIVED BY: _____

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FM-HDU-NOTIFICATION Revision: 2 Effectivity Date: July 1, 2024