Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Dialysis Away from Base (DAFB) Internal Form- 2019

CLIENT DETAILS

Please complete in BLOCK LETTERS.

SURNAME: _____

FIRST NAME: _____

ADDRESS: _____

_____

PHONE _____

MOBILE NUMBER _____

EMAIL _____

DATE OF BIRTH: DAY ☐☐ MONTH ☐☐ YEAR ☐☐

OPTIONAL PHOTO

TREATMENT DETAILS

Please complete 6 weeks prior to travel and confirmation from current provider

COMMENCEMENT TRAVEL DATE: DAY ☐☐ MONTH ☐☐ YEAR ☐☐

COMPLETION DATE: DAY ☐☐ MONTH ☐☐ YEAR ☐☐

Current treatment Location: _____

Proposed Dialysis away from base (DAFB) destination: _____

Number of Dialysis Sessions required: _____

Current Dialysis schedule: (current days on Dialysis) _____

Current Treatment Type: HD ☐ HDF ☐

(TICK WHERE APPROPIATE)

Person completing form

Doctor: ☐ Nurse ☐ Other ☐ _____

Transferred Governance Yes ☐ No ☐

Prescription Transferred Yes ☐ No ☐

CURRENT CLINIC/DOCTOR NAME	**DAFB CLINIC/DOCTOR NAME:**
ADDRESS:	ADDRESS:
TELEPHONE NO:	TELEPHONE NO:
I certify that patient is medically fit for DAFB **Yes** ☐ **No** ☐ **Approved by: _____** **MCRN:** ☐☐☐☐☐	**I agree to accept governance of patient for DAFB** **Yes** ☐ **No** ☐ **Approved by: _____** **Centre Allocated: _____** **Number of sessions allocated: _____**

Initial Date Received		Processed by	
Please complete the following for information:			
Current Provider		DAFB provider	
Number of days/session required			
Outcome- Dialysis received	Parent Unit ☐ Satellite Unit ☐ Refused ☐		
If Refused – by Whom and reason why :	Clinical Issue ☐ Resources ☐		
Offered alternative location If Yes Where: Accepted Yes or No?			
Approved by			
Completed form should be provided to Current Dialysis provider / Hospital Group for payment / Audit and record purposes. **Copy should be forwarded to the National Renal Office**			