UHN Canada's Hospital

Checklist: International Travel Hemodialysis Patient

Instructions: Please have the clinical staff of your home hemodialysis clinic fill out and sign the package. Kindly email the completed package to uhntravellerdialysis@uhn.ca at your earliest convenience. To be considered at one of our sites, we require all information at least 4 weeks before the travel date.

DO NOT BOOK ANY TRAVEL UNTIL WE HAVE SENT YOU A CONFIRMATION OF YOUR RESERVATION

Patient Name:		
#	**Item**	**Check**
1	**Travelling Hemodialysis FAQs & Consent Form –** Page 2 & 3	☐
2	**Travelling Hemodialysis Patient Information Form** – Page 4 to 7	☐
3	**History & Physical Report** – within last 3 months	☐
4	**Orders** completed & signed by Nephrologist	☐
5	**Laboratory Tests** – All tests must be completed within 30 days prior to first date of treatment	
	1. Hepatitis B blood test (HBsAg)	☐
	2. Most recent dialysis lab work CBC, Lytes, Creatinine	☐
	3. Carbapenemase-Producing Organism (CPO) test result	☐
	4. MRSA, VRE test result	☐
	5. TB skin test	☐
	6. COVID PCR Test (within 5 days of travel)	☐
6	**Current Medication List**	☐
7	**ECG Result** – completed in last 3 months	☐
8	**Treatment Records** – 3 recent hemodialysis treatment records	☐
9	**Advance Care Plan:** 1. Ambulance will be called in an emergency 2. CPR performed 3. Possible defibrillation with AED	 ☐ ☐ ☐
10	**Requested Location:** ☐ Mississauga ☐ Yonge & Sheppard	☐
11	**Requested Dates:** **Start:** **End:**	☐

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Travelling Hemodialysis FAQs

IMPORTANT! Who completes this package?

Please have your dialysis unit complete this package and send 4 weeks before your travel date. You MUST receive a confirmation of acceptance email directly from us to receive treatment in our units with your schedule of days and times.

What are the fees for travelling dialysis patients?

For more information on our fees, please contact . We will respond within 1 business day.

Locations and Hours of Operation

We have two Dialysis Unit Location for your convenience:

1. Sussex Centre, 90 Burnhamthorpe Rd. W, Suite 208, Mississauga, ON
2. Yonge & Sheppard Centre, 2 Sheppard Ave. E, Suite 420, Toronto, ON

Our hours of operation are 7:30 AM to 7:30 PM daily. We are closed on Sunday.

How does your dialysis unit work?

We are staffed with experienced dialysis nurses and a medical director. A typical treatment is about 4 hours, and can be less or more depending on your medical situation. If treatment exceeds 4 hours, there will be an additional charge. Your dialysis schedule will be according to our availability, your requirements, and may be subject to change dependent on capacity and staff availability.

We are an ambulatory clinic, meaning you must be self-sufficient with little assistance required to get in and out of chair, walk, washroom, etc. You are solely responsible for arranging pick up and drop off to the clinic.

What is your sick policy?

Any patients who presents sick and/or unstable will not be dialyzed at the satellite unit for safety reasons. You will be sent to the nearest emergency department at your own cost.

WE **DO NOT** ACCEPT PATIENTS WHO ARE HEPATITIS A OR B ANTIGEN POSTIVE, MRSA, VRE, OR CPO POSITIVE

Do you supply medications?

Please bring ALL medications with you, as well as, glucose monitors. We do not provide any medications.

EPO/ARANESP WILL NOT BE PROVIDED, HOWEVER IF YOU BRING YOUR OWN EPO/ARANESP IT CAN BE GIVEN DURING DIALYSIS

How is blood work done?

Blood work may be necessary on the day of your first treatment and every 4 weeks should your stay go beyond 4 weeks. There may be a request for additional lab work if there are any changes observed in your health at an additional cost.

Unit Rules

- Please wear a mask at all times
- 1 visitor at a time is permitted
- There is free Wi-Fi (both sites) and TV available only at Younge/Sheppard location.
- We are in a non-smoking building
- Advise if interpreter needed – price is $75/hour

PLEASE CONFIRM YOUR TREATMENT DATES AND TIMES 48 HOURS BEFORE FIRST ARRIVING AT CENTRE.

Any unforeseen medical issues will be your financial responsibility; your Health Insurance may cover and reimburse some of the costs to you. We recommend that you check with your insurance provider regarding payments for dialysis and the required documentation.

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. Charmaine Lok/Dr. Asad A. Merchant, or associates of their choice to perform upon me haemodialysis and/or any other therapeutic procedures that their judgement may dictate to be advisable for my health and well-being.

3. This consent is for repeated haemodialysis treatment, and as such will be deemed effective for all treatments received to 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 UHN, its staff and associates, from any liability for any complications arising from the dialysis treatment or medical conditions that may occur between dialysis treatments.

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, as well as, any additional tests that will be administered to ensure my wellbeing.

I acknowledge that I have read the above consent and all other information regarding my dialysis treatment at UHN and agree to comply with the policies and procedures at UHN.

Patient Signature: _____

Home Dialysis Nurse: _____

Home Dialysis Nurse Signature: _____

Home Dialysis Phone: _____ Date: _____

INTERNATIONAL PATIENT APPLICATION

I. To be completed by the PATIENT or DESIGNATE

PATIENT INFORMATION	
Patient First Name and Last Name:	**Date of Birth (DD/MM/YYYY):**
Gender ☐ **Male** ☐ **Female** ☐ **I prefer not to say**	**Home Telephone #:**
Permanent Address:	**Mobile Telephone #:** **E-mail Address:**

Electronic Communication: *I understand that all electronic communication has risks and may not be secure. Messages sent to, or from your care provider may be seen or collected by third parties for their own purposes. UHN is not responsible for the security of your internet service providers, email domains, computer, tablet or cell phone or applications (programs) on your device. Electronic Communications may include: Email and SMS text messages.*

I consent to electronic communications with my UHN Care Team.

☐ **Yes** ☐ **No**

RESIDENCY & CITIZENSHIP(S)	
Please list all countries where you have citizenship or residency:	**Canadian Resident:** ☐ **Yes** ☐ **No** **Canadian Citizen:** ☐ **Yes** ☐ **No** **Is the patient currently in Canada?** ☐ **Yes** ☐ **No** **If Yes, for how long?**

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INTERNATIONAL PATIENT APPLICATION

PAYMENT & INSURANCE	
Please indicate how you intend to pay for care at UHN and provide all relevant contact information. All services provided must be paid for in advance of services rendered.	
☐	**Insurance Company:** **Name of Policy Holder:** **Policy Number:** **Contact Information (Phone/E-mail):**
☐	**Paid by Country or Embassy:**
☐	**Paid by Patient:**
☐	**Other (Specify):**

LANGUAGE	
If interpretation is required, UHN policy mandates that an independent interpreter (i.e. not a family member or friend) be present for all medical appointments to ensure informed consent and decision-making. An interpreter will be scheduled by the International Patient Program, and the cost will be built into the estimate provided in advance for the required services.	
Does the patient speak & understand English sufficiently to make informed decisions? ☐ **Yes** ☐ **No**	**If no, list language for interpreter services:**
Interpreter: **I have done my best to translate this form from English to _____ and will not divulge any information.**	**Interpreter Name:** **Date:** **Signature:**

INFORMATION AND AUTHORIZATION FOR COMMUNICATION WITH REPRESENTATIVE(S)	
Please list any representative(s) that will be providing support or accommodation. *Your representative will support **communication only** between yourself and your UHN care team. Your representative may share information with UHN under your direction but does not have the authority to make decisions for you about your care.*	**Name:** **Relationship:** **E-mail:** **Phone:** **Name:** **Relationship:** **E-mail:** **Phone:**

UHN Canada's Hospital

INTERNATIONAL PATIENT APPLICATION

AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

This Authorization to Release or Obtain Health information section pertains to the disclosure or retrieval of your personal health information. ***This authorization may be withdrawn at any time and no further information will be shared. Please note if information has already been shared, that information cannot be retracted.***

I authorize UHN-International to discuss, disclose or obtain personal health information relating to my care at University Health Network to:

Insurance **Lawyer** **Care Provider**

Other(Family, Friend, Spouse etc). If Other, please specify relationship to patient:** _____

Relating to treatment period for: _____

Recipient Name:		**Recipient Name:**	
Relationship:		**Relationship:**	
Phone:		**Phone:**	
E-mail:		**E-mail:**	
Fax:		**Fax:**	

Print Patient Name/Substitute Decision Maker:	**Print Name of Witness:**
Signature and Relationship (if applicable):	**Signature of Witness:**
Date:	**Date:**

UHN Canada's Hospital

Travelling Hemodialysis Patient Information

Patient Demographic Information	
Patient Name:	Gender:
Birth Date:	Email:
Home Address:	
City:	Province/State:
Country:	Postal/ZIP Code:
Telephone:	Mobile:

Emergency Contact Information (when in Canada)	
Contact Name:	
Telephone:	Mobile:
Contact Address:	
City:	Province:
Postal/ZIP Code:	Email:

Home Dialysis Unit Information	
Referring Hospital (Clinic):	
Telephone (incl. country code):	
Fax (incl. country code):	
Referring Nephrologist:	Email:
Telephone (incl. country code):	Fax (incl. country code):

Patient Travel Information	
Reason for Visit: ☐Vacation ☐Business	
Address While Visiting:	
City:	Postal/ZIP Code:
Telephone: Click or tap here to enter text.	
Local Contact Person:	Contact Telephone:
Person Arranging Care: ☐Self ☐Other	If Other, Name:

Relationship:	Telephone:
Medical Information	
Allergies:	Renal Diagnosis:
Diabetes Mellitus: ☐Yes ☐No	Insulin Dependent: ☐Yes ☐No
Other Medical Conditions:	
**Please affix a list of medications to this package*	
Current Hemodialysis Treatment Information	
Dialysis Days: ☐Mon ☐Tue ☐Wed ☐Thu ☐Fri ☐Sat	
Language(s) Spoken:	Interpreter needed: ☐Yes ☐No
Mobility Needs: ☐Independent ☐Uses Mobility Aide(s),	
Aide Type(s):	
Fall Risks (Specify):	
Patient AV Access: ☐Fistula ☐Graft	**Needle Gauge**: ☐16g ☐15g
Time for Homeostasis:	
Central Venous Catheter (CVC): Arterial Lumen: ml Venous Lumen: ml ***Patient to bring caps for duration of stay***	
Blood work required (type & frequency):	

UHN Canada's Hospital

Hemodialysis Orders				
Patient Name:			Target Weight (Kg):	
Start Date:			Access Type:	
Instructions: Please check ONE box for each order				
Dialyzer	☐ Elisio 17 H	☐ Elisio 19 H	☐ Elisio 21 H	☐ Elisio 25 H
Dialysis Time	☐ 4 hours	☐ 3 hours	☐ 2 hours	☐ Other:
Blood Flow (ml/min)	☐ 300	☐ 350	☐ 400	
Dialysate Flow (ml/min)	☐ 500	☐ 800		
Dialysate Temp (Celsius)	☐ 36.0	☐ 36.5		
Dialysate Sodium (mEg/L)	☐ 138	☐ Other: _____		
Dialysate Potassium (mEg/L)	☐ 1.0	☐ 2.0	☐ 3.0	
Dialysate Calcium (mEg/L)	☐ 1.25	☐ 1.5		
Dialysate Bicarbonate (mEg/L)	☐ 35	☐ 40		
Anticoagulation (Heparin Only)	☐ No Heparin	☐Normal saline flushes 200ml/hr		
Heparin Bolus (Units/hour)	☐ 500	☐ 1000		
Heparin Hourly (units/hour) (discontinued 1 hour before end of dialysis)	☐ 500	☐ 1000	☐ None	
Erythropoietin	☐Eprex Dose: Frequency:	☐ Aranesp Dose: Frequency:		
CVC Locking Agent (if applicable)	☐ Sodium Citrate 4%	☐Heparin 1000 units/ml		
Nephrologist Signature:			Date:	

Other Considerations

If there are additional considerations not defined on this form, please add below. Please contact us at your earliest convenience to discuss: *(ie. Access cannulation information, preparation of dialyzer, patient to bring own dialyzer, bring own needles, etc.)*

Attestation & Signature

I,_____*(First/Last Name),* certify that this package has been completed by a licensed healthcare professional directly affiliated with my hemodialysis care at my home clinic.

Package Completed by:_____Date: _____

I,_____(*First/Last Name),* certify that this package contains all accurate and recent information regarding my health condition(s). I agree to update UHN should there be any changes to my medical status prior to arriving for hemodialysis treatment

.

Signature Applicant: _____ Date: _____

CONDITIONS OF ACCEPTANCE AS A PATIENT
(Non-Residents of Canada or Uninsured Canadian Residents)

As a Canadian hospital, it is the policy of the University Health Network (UHN) that all patients seen or treated on an elective basis that do not have Canadian federal, or provincial health insurance must prepay all known hospital fees before being accepted as a patient. We may accept private insurance coverage in lieu of prepayment for such patients once approved by the Corporate Billings & Accounts Receivable department of UHN and once coverage is pre-certified in writing directly by the insurer.

In certain cases, it may be necessary to see patients and perform certain testing and investigation before the known treatment plan can be developed. In such cases, UHN will estimate what the likely hospital fees related to the investigation and likely treatment plan will be and they must be paid and received by UHN before any further investigations and treatments start.

CONDITIONS:

1. Prepayment or approval of private insurance coverage is not a guarantee or a commitment to proceed with any hospital visit, nor does this obligate UHN to provide treatment if a treatment plan is developed.
2. Treatment at UHN will only proceed if all of the estimated hospital fees for the known treatment plan are paid, or private insurance approved, 10 business days in advance of the first date of service.
3. The University Health Network reserves the right to decline treatment of such patients that are willing to pay for services if:
   - Placing the patient on the service waiting list would unreasonably prolong the waiting time for Insured Ontario and Canadian residents;
   - Resources for the required service are not available.
4. Regardless of what the estimated fees are, patients will only be charged the related hospital fee for actual services rendered at UHN. See related hospital estimate.

Signing below indicates your understanding and agreement to abide by these conditions.

Return the signed original document to: UHNtravellerdialysis@uhn.ca

SIGNATURE OF PATIENT or SUBSTITUTE DECISION MAKER	SIGNATURE OF WITNESS
PRINTED NAME	PRINTED NAME
DATE	DATE
PRINTED NAME OF PATIENT IF SUBSTITUTE DECISION MAKER REQUIRED	PRINT NAME OF TRANSLATOR (IF REQUIRED)
	SIGNATURE OF TRANSLATOR

Form D-2364 (21/11/2013)
updated (28/01/2019)

Governing Law and Jurisdiction Agreement
for healthcare organizations

This agreement ("Agreement") is entered into by and between _____ and
[Name of patient]

UNIVERSITY HEALTH NETWORK (collectively, the "Parties").

Governing Law

The Parties hereby agree that:

a) all aspects of the relationship between _____ and UNIVERSITY HEALTH NETWORK
[Name of patient]
(as well as her/his agents, delegates, employees, and any physicians and other independent healthcare practitioners providing medical or other healthcare and treatment to _____,
[Name of patient]
or in association with UNIVERSITY HEALTH NETWORK), including without limitation any medical or other healthcare and treatment provided to _____, and
[Name of patient]

b) the resolution of any and all disputes arising from or in connection with that relationship, including any disputes arising under or in connection with this Agreement, shall be governed by and construed in accordance with the laws of the province or territory of ONTARIO (other than conflict of laws rules) and the laws of Canada applicable therein.

Exclusive Jurisdiction

The Parties hereby acknowledge that the medical or other healthcare and treatment received by _____
[Name of patient]
from UNIVERSITY HEALTH NETWORK will be provided in the province or territory ofONTARIO, and that the Courts of ONTARIO shall have exclusive jurisdiction to hear any complaint, demand, claim, proceeding or cause of action, whatsoever arising from or in connection with that medical or other healthcare and treatment, or from any other aspect of the relationship between

_____ and UNIVERSITY HEALTH NETWORK.
[Name of patient]

_____	_____
SIGNATURE OF PATIENT / SUBSTITUTE DECISION-MAKER ON BEHALF OF PATIENT	SIGNATURE OF WITNESS
_____	_____
PRINTED NAME	PRINTED NAME
_____	_____
DATE	DATE
_____	PER: UNIVERSITY HEALTH NETWORK
PRINT NAME OF SUBSTITUTE DECISION-MAKER or TRANSLATOR (IF REQUIRED)	

UHN Canada's Hospital

Notification of Change in Status Agreement

Please note that if you are in the process of obtaining OHIP coverage or permanent residency in Canada you must provide this information (including the status of your OHIP coverage application) as a part of your application.

International fees are in effect until Altum Health is provided with appropriate official documentation as to any change in your status.

In order to avoid incurring International fees, you must provide the relevant official documentation to Altum Health at least 2 weeks prior to any scheduled services. Please note that no retroactive requests with respect to the reversal of International fees will be honored under any circumstances.

I,_____have read and understand the above information and consent.
(Print Full Name)

Patient Signature:_____ Date: _____

Address: _____
Phone Number: _____

Witness Signature:_____ Date: _____