Call Center int. patients +30 22410 45045
info.rhodes@imitheamg.gr • dialysis.rhodes@imitheamg.gr
Koskinou, P.O.box 22113, 851 05, Rhodes - Greece

dialysis centre

APPLICATION FORM FOR HOLIDAY DIALYSIS

Dear **patient**,
Please make sure you save this form prior to closing it.

Name ..... **Date of Birth** ...../...../.....

Home Address ..... (Street) ..... (City) ..... (Zip)

Country ..... **E-mail** .....

Telephone Nr ..... **Mobile Nr** .....

Date of Arrival ...../...../..... **Name of Hotel in Rhodes** .....

Holiday Dialysis Schedule MON/WED/FRI ...../...../...../...../...../...../...../...../...../...../...../...../...../...../

...../...../...../...../...../...../...../...../...../...../...../...../...../...../

Holiday Dialysis Schedule TUE/THU/SAT ...../...../...../...../...../...../...../...../...../...../...../...../...../...../

...../...../...../...../...../...../...../...../...../...../...../...../...../...../

Preferred time of treatment ☐ **Morning** ☐ **Noon**

Contact person in case of emergency .....

Type or relationship of contact with patient .....

Tel. Nr. of contact person ..... **E-mail** .....

Name of your Dialysis Center ..... (City) ..... (Country) ..... (Postal Code)

Address .....

Nephrologists ..... **Telephone Nr** .....

Please note that a medical report is required upon arrival

PAYMENT METHOD

☐ **Cash** ☐ **Private Insurance** **Name of Insurance Co.** .....

EHIC Nr ..... **Expiry Date** ...../...../.....

(please include a copy of both sides of the EHIC card)

OTHER RELEVANT INFORMATION

Travel Insurance ..... **Policy Nr** .....

Transplant List Since ...../...../.....

Notes / Comments: .....

Signature of Patient

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MEDICAL DATA TO BE COMPLETED BY A DOCTOR

Dear **patient**,
Please make sure you filled page 1 of the form and THEN send this form to be completed by your doctor.

Dear **doctor**,
Please make sure you save this form prior to sending it.

Type of dialysis treatment you are currently receiving

☐ Haemodialysis ☐ On-Line Hemodiafiltration

Type of dialyzer: ..... Surface: .....

Dialysis Information

Blood group: ..... Rhesus factor: .....

HBsAg	☐ positive	☐ negative	dated ../../..
HCV (Hepatitis C-virus)	☐ positive	☐ negative	dated ../../..
HIV-test	☐ positive	☐ negative	dated ../../..
MRSA-infection	☐ positive	☐ negative	dated ../../..

Diagnosis and history: PLEASE ENCLOSE LETTER

Haemodialysis schedule: Times per week ..... Duration ..... hours.
Vascular access: ..... left / right; one / two needle(s)
Needle size: ..... Buttonhole: ☐ yes ☐ no
Blood pressure: ..... mmHg (ante dialysis) / ..... mmHg (post dialysis)
Dry weight: ..... kg Average ultrafiltration need: ..... Urinary volume/24 hrs.: ..... ml
Blood pump: ..... Dialysis Fluid Flow: ..... Temperature: .....
Composition of dialysate: ..... K+ ..... Ca++ ..... Bicarb ..... Concent ..... Na+ .....
Heparinization: ..... ml. Initial: ..... ml. Following doses: ..... ml.

You should carry your HD medication with you.

Allergies: .....

Present medication: please enclose medication list not older than 3 month Laboratory results: please enclose laboratory results not older than 3 month

History of the last six months:	yes	no
Unstable angina pectoris	☐	☐
Heart problems	☐	☐
Hyperkaliaemia	☐	☐
Shunt problems	☐	☐
Serious infections	☐	☐
Surgery	☐	☐
Haemodynamic instability during haemodialysis sessions	☐	☐

Other complications ☐ yes ☐ no

Mobility
The patient depends on a wheel chair / has trouble walking or please specify any physicals requirements

Signature of nephrologist in charge

CONSENT TO THE PROCESSING OF YOUR DATA

I, the undersigned .....

☐ **CONSENT** ☐ **DO NOT CONSENT**

to the processing of my personal data (simple and health/special categories data) included in this form (or sent together with this form) by the Company and its doctors, in accordance with article 9 par. 2 (a) of the General Data Protection Regulation (EU) 2016/679 (hereinafter "GDPR") according to the following notification.
I have been informed that I have the right to withdraw this consent at any point of time.

Date: ...../...../..... **Signature:** .....

NOTIFICATION

The company under the name "GENIKI KLINIKI DODEKANISOU SINGLE MEMBER S.A.", based in Rhodes, Dodecanese (Koskinou Area, tel. 2241045000, e-mail: info.rhodes@imitheamg.gr) (hereinafter "Company") informs the natural persons that submit the present form of the following:

1. The Company, as a data controller, processes the simple and health/special categories personal data included in this form for you, as you wish to receive dialysis treatment in the Company's clinic in Rhodes during your stay in Rhodes.

2. The purpose of the processing of the aforementioned personal data by the Company is to prepare for the provision of dialysis treatment to you, while the legal basis of the processing is your consent (article 9 par. 2(a) of the GDPR).

3. The processing of your personal data will be carried out in accordance with the principles of personal data processing set out in Article 5 of the GDPR.

4. Your personal data might be shared with collaborating doctors and the Company staff that are entrusted with the preparation of your dialysis treatment and might be accessed by associates of the Company entrusted with the support of health services management systems.

5. Your personal data will be stored by the Company for a period of four (4) months if you don't receive medical treatment by the Company. If you receive medical treatment by the Company, the personal data included in this form will follow your medical records and will be stored by the Company for a period of ten (10) years.

6. The Company implements all appropriate technical and organizational measures, which are constantly being reviewed and updated, in order to ensure a high level of data protection.

9. You can exercise at any time the right to access your medical records, to object (objection right), to limit the processing, the right to rectification and erasure, as well as the right to data portability, if this is possible. You also have the right to complain to the Hellenic Data Protection Authority (www.dpa.gr), in case of violation of your personal data. For any further information regarding the processing of your personal data, for the exercise of your rights, or for the submission of a complaint, you may contact the Data Protection Officer of the Company, through telephone number (+30 210 3686700) or through email (dpofficer@imitheamg.gr)

I declare that I have read this notification carefully.

..... (location), .../...../.....

(Name) ..... **Signature:** .....

The representative in the name / by order / on behalf of the above patient. In case of a minor up to the age of 16 years, all statements are signed by the parent.

(Name) ..... **Signature:** .....