CHUUK STATE GOVERNMENT

DEPARTMENT OF HEALTH SERVICES
State of Chuuk
Federated States of Micronesia 96942

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CHUUK STATE HEMODIALYSIS CENTER

SHORT-TERM VISITING PATIENT REGISTRATION & GUIDELINES

SECTION 1: VISITING PATIENT REGISTRATION FORM

1. Personal Information

- Full Name:
- Date of Birth:
- Age: _____
- Gender:
- Passport / ID Number:
- Home Address (Country):
- Phone Number:
- Email Address:

2. Travel Information

- Date of Arrival in Chuuk:
- Date of Departure from Chuuk:
- Length of Stay:
- Local Contact Person:
- Local Contact Number:

3. Home Dialysis Center Information

- Dialysis Center Name:
- Address: _____
- Contact Person: _____
- Phone / Email: _____

4. Medical Information

- Primary Diagnosis: _____
- Date Started Dialysis: _____
- Treatment Schedule: ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun
- Frequency: ☐ 2x/week ☐ 3x/week ☐ Other: ____

- Hemodialysis Referral Form from current dialysis clinic or hospital.
- Latest three treatment sheets
- Copy of latest lab results including CBC, Chemistry, HIV, Hepatitis, Electrolytes, CXR, EKG
- List of maintenance medications.

SECTION 2: GUIDELINES FOR VISITING PATIENTS

1. Advance Booking
- Must be arranged at least 1 week in advance.
- Subject to availability and clinical review.

2. Treatment Schedule
- Based on center capacity.
- Patients must adhere strictly to assigned schedule.

3. Arrival & Preparation
- Arrive 30 minutes before treatment.

4. Medical Responsibility
- This center provides temporary dialysis care only.
- Primary care remains with the patient's home physician.

5. Infection Control
- Compliance with all infection prevention protocols is required.

6. Emergency Protocol
- Patients may be referred to hospital services if needed.

7. Financial Policy
- Cost: $300 per session and $500 per session beyond the pre-arranged sessions.
- Full payment for the total number of scheduled sessions is required in advance prior to approval and confirmation of services.
- Scheduling is not confirmed until payment is received in full.
- Payments are non-refundable once services are confirmed, except under special circumstances approved by management.
- All costs are the responsibility of the patient.

8. Cancellation Policy
- Minimum 48- hour notice required.
- Late cancellations may be charged.

9. Patient Responsibility
- Follow all medical and facility guidelines.
- Maintain communication with healthcare providers.

10. Inquiries & Contact Information:

- For questions regarding registration, scheduling, required medical documents, or payment, please contact the **Chuuk State Hospital** before making travel arrangements.
- **Phone:** (691) 330-2214/2216 / 2217
- **Email:** Dr. Bosco Buliche - b2@fsmhealth.fm Dr. Dorina Fred – dfred@fsmhealth.fm Dr. Julius Arsenal – jojoares901@gmail.com Dr. George Pariwa – georgepariwa@yahoo.com Romeo Doble – romeo.doble@medpharmusa.net
- **Office Hours:** Monday–Friday, 8:00 a.m. – 5:00 p.m. (Chuuk Time)

SECTION 3: FINANCIAL AGREEMENT & SIGNATURE ACKNOWLEDGMENT

I, _____, acknowledge and agree to the following:

1. I understand that the cost of hemodialysis is $300 per session & $500 per session beyond the number of pre-arranged sessions.
2. I agree that full payment for all scheduled sessions must be made in advance prior to approval and confirmation of treatment.
3. I understand that no dialysis services will be provided without full prepayment.
4. I acknowledge that payments are non-refundable once services are confirmed, except under special circumstances approved by the center.
5. I accept full financial responsibility for all services provided during my stay.

I further acknowledge that I have read, understood, and agreed to all registration requirements and patient guidelines.

Patient Name: _____

Patient Signature: _____

Date: _____

SECTION 4: FOR OFFICE USE ONLY

- Patient Name:_____
- Approved Dates: _____
- Assigned Schedule: _____
- Machine #: _____
- Nurse Assigned: _____
- Date Confirmed: _____