Problem list format

NAME	ID NUMBER
DOB	DATE of commencing dialysis
REFERRING DOCTOR	CENTRE

PRIMARY DIAGNOSIS: ----------

COMORBIDITIES

CONDITION	Duration	COMMENT
Diabetes Mellitus		
Hypertension		
Coronary Artery Disease		
LV EF		
Peripheral Neuropathy		
Retinopathy/ Vision		
Cerebrovascular Disease		
Respiratory Disease		
Malignancy		
Haemoglobinopathy		
Peripheral Vascular Disease		
Hepatitis B		
Hepatitis C		
HIV		
Malnutrition		

Major Events	Date	Comments