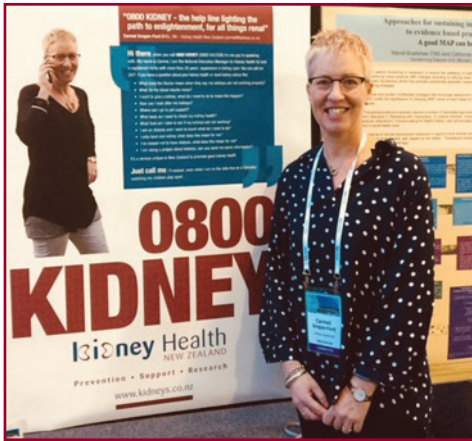


IN THIS ISSUE

KHNZ update • CEO update • Claire's story • First Tongan Nurse practitioner
• From our fundraiser

KHNZ update

I hope you are managing to keep warm and free of the usual winter bugs that are common at this time of the year. I always feel happy when the shortest day has been and gone as it means Summer is just a little bit nearer. It has been another busy time with the annual Renal Society of Australasia (RSA) being held in Adelaide in June, I was kept busy chairing a session, adjudicating two sessions and presented a poster promoting our free phone help line.



Promoting the free help line at the Renal Society of Australasia annual conference in Adelaide.

The following are some of the highlights from the conference:

The first speaker received a standing ovation after a truly inspirational talk. Dr Gill Hicks an advocate for sustainable peace and a valuable resource in countering violent extremism, Gill is widely considered one of the world's most thought-provoking, powerful and life-affirming speakers.

Her devotion to making a personal greater contribution and positive difference to the urgency of building peace was realised when she was made permanently injured losing both of her legs in the London bombings on July 7th, 2005.

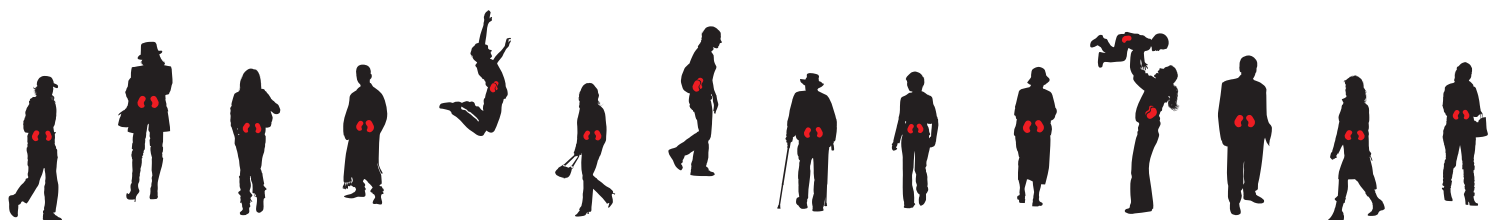
Her 'lived experience' -- from survival to rehabilitation as a double amputee -- created a clear demarcation from all she had known before the bombings.

Her 'second life' is built on what she describes as a series of conscious choices, mindfulness and being aware of the importance of the

moment. Gill shared what she has learned about herself, humanity and the extraordinary and inherent ability to rise in the wake of adversity.

Dr Paul Lawton talked about the provision of dialysis for Indigenous Australians, what's important and why? He challenged kidney disease care disparities and outcomes among Indigenous Australians and using larger already existing data describing the issues particularly in the Aboriginal population and gave examples of how we can do better for disadvantaged populations. He talked about the need to address racism in the health system and that one size healthcare does not fit all; it results in systems designed for white people or the dominant group, rather than the cultural minorities. Culturally safe health systems are more likely to be used by those groups in greatest need of healthcare. Dr Lawton was very passionate, it's wonderful to see someone so dedicated in this area.

Anthea White spoke passionately about waste in haemodialysis and her project to monitor and reduce clinical waste. Anthea talked about the fact that there are around 10,000 people receiving haemodialysis in Australia with each producing 1.5 – 8 kg waste per treatment, depending on machine and consumable choice. There is growing realisation across the healthcare sector that the amount of waste produced, along with the associated environmental and financial costs, must be addressed. Following intensive education of staff and patients



about appropriate waste segregation, clinical waste was reduced by almost 49% per dialysis treatment. In the quarter September – December 2017, 1.25kg clinical waste was produced per dialysis treatment which is as low as can be practically achieved given the consumables currently used. Furthermore, recycling of PVC has resulted in 70kg of waste per month being diverted from landfill. Together, these waste management strategies from 2013 – 2017 have resulted in savings of 32,500kg of waste, equivalent to approximately \$29,000. Following Anthea's passionate talk, I spoke to her about the initiatives and what we can do in NZ to support this work, we hope to run a workshop at the next RSA conference in 2019 around what we can do to reduce the environmental impact from dialysis.

Dr Janet Kelly talked about improving the Aboriginal patient journey for patients with kidney disease, a lot of work is being done around storytelling, combined with visual cues used to help educate families. The key aims of the program are 1. To help people on their return to country. 2. Help people with their families to live the best life possible 3. The organisation will work hard to do the best we can for patients, families and stakeholders.

Another interesting talk was from the team at Austin Health the use of USB sticks for patients. Satellite dialysis patients often have multiple comorbidities, receiving care from multiple medical specialties. Dialysis unit staff reported ongoing difficulties with compiling accurate patient medication lists for monthly renal reviews. It was felt this problem could be addressed by giving patients a way of real time tracking their medications and changes made by all treating doctors. A Microsoft word medication chart was developed, and renal medical and nursing staff educated. Fourteen patients in three satellite dialysis units each received education and their own USB loaded with a medication list. With the positive response from patients and success of the project in providing increased empowerment over healthcare coordination, the project roll out to all patients is in progress.

Dr Shilpa Jesudason is the Clinical Director for Kidney Health Australia and a Staff Specialist Nephrologist (Central Northern Adelaide Renal and Transplant Service (CNARTS) and Consulting Renal Physician (Women's and Children's Hospital). She runs a monthly Obstetric Nephrology Clinic for pre-conception counselling, antenatal care and post-partum follow up of women with renal disorders. In the first of her two sessions Shilpa talked about pregnancy in women after kidney transplantation. She talked about the fact the motherhood is a goal and aspiration for many women, with grief and loss occurring when this happens. There are many fears and insecurities that affect the decision to have a child post-transplant such as fears about their own health and survival, fear of harm to the baby and guilt over "gambling" with the precious transplant. Pregnancies in transplanted women are high-risk with 30-50% developing pre – eclampsia, 50-60% developing or worsening hypertension and 60% have a caesarean section, as well as around 50% babies being born preterm.

Shilpa also talked about the effect of the pregnancy on the transplanted kidney, with temporary or permanent decline in function not uncommon. It is advised to wait 3-5 years post-transplant before conceiving. Breast feeding is discouraged due to the risk of some of the immunosuppression medications crossing into the breastmilk. Pre-pregnancy planning is very important to ensure informed and shared decision making, especially as medication such as MMF/Sirolimus needs to be stopped and replaced with azathioprine.

I was also fortunate enough to get a tour of the renal unit at the brand new Royal Adelaide Hospital with Shilpa, it was quite something, with single rooms for most patients and an eight bedded acute dialysis facility included within the ward, the nephrology offices are on the same floor with a very spacious feel to the whole floor.

With Diabetes Mellitus being the leading cause of end stage kidney disease in both NZ and Australia, it is a common topic at these events. Dr Jessica Stranks (FRACP) is a Clinical Endocrinologist working in Adelaide, she spoke about the proportion of those with Type 2 Diabetes continuing to rise. For every patient with diabetes receiving some form of renal replacement therapy at least 50 others have diabetic kidney disease. Diabetic patients do worse on dialysis in terms of survival, this is due largely on the effect of higher cardiovascular mortality rates. The importance of intensive blood sugar control in preventing complications of diabetes in both Type 1 and Type 2 (particularly microvascular, small blood vessel, complications) Dr Strank also talked about the advances in diabetes technology, which was very interesting, such as the continuous glucose monitoring system that can deliver blood sugar measurements to a smart phone. In the area of transplantation and diabetes there is research being done in diabetes "friendly" immunosuppressive regimens, with newer drugs expanding into this area.

The conference ended with this wonderful quote:

*For life is quite absurd and deaths the final word
You must always face the curtain with a bow
Forget about your sin, Give the audience a grin
Enjoy it – it's your last chance anyhow!
Always look on the bright side of life!*

(attrib Monty Python)

In July I visited Westport and Greymouth, where I gave two education sessions to patients about the risk factors for kidney disease and how to look after your kidneys, and then an evening session for nurses working in primary care talking about identifying and managing chronic kidney disease in their practice, two nurses dialed in from Fox Glacier and Buller via video conference. I did some kidney health screening for those who were keen and had great interest with around 40 people having their blood pressure and urine tested. I can report the West Coast hospitality lived up to its reputation, I was well looked after.

I've just returned for the annual GP conference held in Auckland. We had a stand promoting our work and raising our profile within General Practice. With over 800 delegates it was a great opportunity to spread the word about KHNZ and the feedback I received about our resources was very encouraging with many GPs already using our guideline tool to manage their patients with kidney disease. They were very keen to see our Chronic kidney disease resource for patients with several orders for these brochures. It was certainly a very worthwhile few days.

From the CEO

Kia ora koutou.



I'm writing this en route home from attending the BEAT CKD Research Forum in Brisbane. Despite suffering from 'acronym fatigue' – we received updates on various clinical studies including BEST-Fluids, RESOLVE, REMOVAL-HD, PREXIVAS and PROMS, to name a few – it was an incredible conference.

BEAT CKD stands for 'Better Evidence and Translation in Chronic Kidney Disease' and is a collaboration between the Australasian Kidney Trials Network (AKTN), the Australia and New Zealand Dialysis and Transplant Registry (ANZDATA), the Kidney Health Australia 'Caring for Australasians with Renal Impairment' Guidelines initiative (KHA-CARI) and Cochrane Kidney and Transplant (CKT). More acronyms than is probably healthy!

The first day of the forum focused largely on various clinical studies and trials being undertaken across Australia and New Zealand. Important stuff. But the forum really came to life for me on Day 2, where the focus shifted to consumer engagement – particularly in terms of consumer involvement in research. What was apparent was that how **researchers** may have (certainly in the past) defined consumer engagement, and how **consumers** would define such engagement can be quite different. Recognising this, there is now a clear shift from researchers undertaking studies **on** and **to** kidney patients, to research that is undertaken **with** and **for** patients. Indeed, the World Health Organisation, national research ethics committees and research funders all now expect to see how a study or clinical trial is actively involving patients in the co-design, undertaking and even the writing up of such research projects.

Who gets to decide which outcomes are of the most importance – the clinician or the consumer?

Likewise, there is a clear move towards renal patients and their families having a role in setting the research agenda. Yes, any clinical study is designed to improve clinical practice and ultimately improve clinical outcomes for the patient. But who gets to decide which outcomes are of most importance – the clinician or the consumer?

You may recall reading in an earlier newsletter of the SONG-HD research project, undertaken by the Standardised Outcomes in Nephrology Group. This international initiative, based out of Australia, has enabled **both** clinicians and haemodialysis patients to each identify what health outcomes are of most importance to them and, through a series of surveys and workshops, identify and agree on which of an extensive range of outcomes are **most** important and should be prioritised for future research. That process has enabled clinicians to recognise that some outcomes that they see as of critical importance (e.g. vascular access, potassium levels, etc.) may not be as important as fatigue and the ability to travel and work are to patients on haemodialysis. And that, in turn, positions such **patient**-focused outcomes as equally important in terms of the research agenda.

From a consumer perspective, the experience of renal care was just as important as the outcome of that care - and that both deserve to be measured.

The BEAT CKD collaborative is currently developing a major research initiative to develop a suite of patient-reported outcome measures (PROMs, to add yet another acronym to the list). A similar study (which I touched on in the last newsletter) has been undertaken in the UK over the past couple of years developing patient reported experience measures (PREMs). Similar – but, in one vital aspect, different. The BEAT CKD initiative will be seeking to identify and measure what **outcomes** are important to renal patients. The UK research, on the other hand, focused on what was important to renal patients and their carers in terms of their **experience** of renal care. How accessible is your renal team? How much of an issue is transport to you as a renal patient? Is the information provided to you by the renal team easy to understand? How involved do you feel in the decisions made about your care?

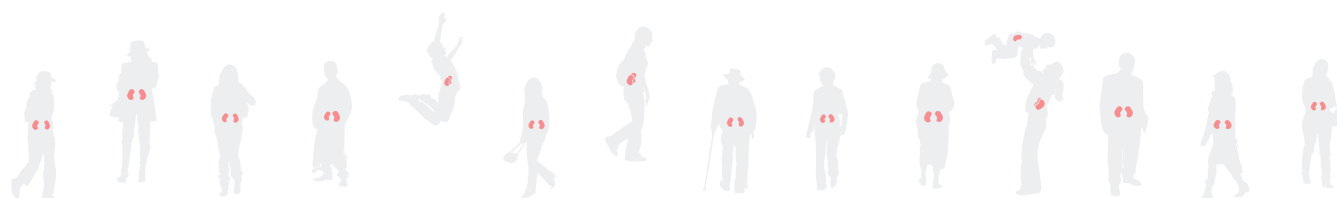
What was abundantly clear from the Brisbane research forum was that, from a consumer perspective, the **experience** of renal care was just as important as the **outcome** of that care – and that both deserve to be measured. At a practical level, this presents Kidney Health New Zealand with a couple of useful challenges or opportunities (depending on whether you take a glass half full or half empty perspective).

Firstly, while New Zealand will have input into the outcomes-focussed PROM research initiative, discussions with that project's lead researcher suggest that KHNZ replicating the UK's patient experience-focussed PREM research would be equally valuable and provide a useful complement to the PROM initiative.

Secondly, the BEAT CKD collaborative has recently been in the process of establishing a Consumer Advisory Board. Despite three of the four organisations in the collaboration having 'Australasia' in their title, the Consumer Advisory Board doesn't yet have any NZ renal consumer representation. With the collaborative's support, we have reproduced their original call for Consumer Advisory Board membership elsewhere in this newsletter, and I'd warmly encourage anyone interested in becoming involved in this way to apply to the BEAT CKD team.

Regards,
Max.

If you are interested in applying use the link below to access the application form:
<http://beatckd.org/consumeradvisoryboard/>



Claire's Story

My name is Claire, I live in Christchurch, New Zealand and this is my story.

I was a happy, healthy 16-year-old school girl who loved life. Then literally overnight, my whole world came crashing down. One day I was a perfectly normal teenager, the next day my life would never be the same.

I lived in Invercargill at the time. On the day of my 6th form prize giving, and in full health, my friend and I had a girls' night in with DVDs and junk food - the perfect night! The next morning, I woke up with swollen hands and face. Little did I know, this was the beginning of the hardest battle of my life.

Thinking I was having an allergic reaction, my sister and I went to A and E Friday morning, and I was sent home on antihistamines. By Sunday my whole body was so swollen I could hardly move. This time we knew it was serious.

Back in hospital, I was diagnosed with acute kidney failure. My kidneys had stopped. No urine could leave my body, and I was seriously ill. Hoping it was temporary, the doctors prescribed intense doses of steroids. A variety of medications, chemotherapy, transfusions, none of it worked. I got sicker and sicker. My body gained 25kgs of fluid in 2 weeks. Every liquid that went into my body remained in, poisoning my body. And so, my dialysis journey began.

We moved to Dunedin to be near the hospital, which became my 'home away from home' for the next few years. Invercargill does not have any renal services. This means all renal patients in Southland or the lower South Island have to travel to Dunedin. My mum and I were trained in how to do dialysis, and I regained some strength. A dialysis machine was installed at home in Invercargill, and finally, we moved home.

I was diagnosed with an extremely rare disease. So rare that a cure is still being researched. It's called Focal Segmental Glomerulosclerosis (FSGS for short). For the next three years I relied on a haemo dialysis machine to keep me alive. Hooked up by needles, four times a week for four hours, while fluid and toxins were removed from my body. A fluid restriction of 700mls a day made it even harder. This included fruit and sauces, even ice cream. An orange is 150mls - that's nearly a quarter of my daily allowance! Something as simple as drinking can be taken away from you is awful. Food restrictions were applied too, to keep my sodium, potassium and phosphate levels low. Being on dialysis is hard enough, add in the fluid and food restrictions makes it even more difficult.

Just before my 21st birthday, my amazing sister was given the all clear to donate a kidney to me. It was a dream come true! I could see the light at the end of the tunnel. My specialists warned me that that they didn't know what would happen, and that my disease could come back, but I was optimistic.

We had the operation January 2011. It worked straight away, but that very first night the disease attacked it. It went into shock and went to "sleep", it hadn't failed but it was badly damaged. With a variety of intensive treatments of plasma exchange and another treatment called Rituximab it woke up and we kept it going. I had three amazing dialysis-free years. It was so good. But eventually it failed in February 2014, just as my now husband, and I moved to Christchurch.

I am now back on haemo dialysis every second day for four and a half hours and it's hard. It makes me so sick, tired and miserable. I did get the opportunity to do peritoneal dialysis. I started with manual bags, 4 times a day, then moved onto the night time one. PD worked really well for me. I felt healthy and well! Unfortunately, that came to a very scary end and I was put back on haemo dialysis. It's been nearly 10 years of battling to live. Battles with seizures from blood pressure issues, numerous operations, failed peritoneal dialysis due to my peritoneal cavity failing after 18 months, and many, many other hard and difficult situations all connected to renal failure. In April 2016 I had a massive cardiac arrest with a 2% survival rate, all due to dialysis not working properly. My life can be absolutely terrifying sometimes, for me and my family. I'm not eligible to receive a deceased donor kidney from the national transplant list due to my unique disease. I will never have the opportunity to receive 'the call' that tells you a kidney is waiting.

I have still achieved wonderful things on dialysis. We went to Hawaii for 10 days when I was on peritoneal dialysis. We got married in November 2017 and went on honeymoon to Australia. All things I never thought I would live long enough to do. But I did it. I survived and have become stronger with every hurdle thrown my way.

I need an angel to come and save me and donate a kidney to me. Someone who can give me a life again. A life not dependent on a dialysis machine to keep me alive. I just need one person to help me.

Below we recognize one of the six renal nurse practitioners in New Zealand, thank you to Kai Tiaki Nursing New Zealand journal for letting us reprint this.

First Tongan Nurse Practitioner - Fakaola I Vaiola Otuafi



Fakaola Otuafi's first experience nursing patients with renal disease was as a student. Despite the complexities of this area of practice, her passion remains undimmed.

Nurse practitioner (NP) Fakaola I Vaiola Otuafi has always known her strengths and real interests are in clinical nursing. Born in Tonga, she was inspired by her mother, who was a midwife, to become a nurse. In 1997, she was offered a New Zealand scholarship to study for her Bachelor of Nursing at the Manukau Institute of Technology. Her last placement as a student was in the renal service at Counties Manukau District Health Board (CMDHB), and she has never looked back. Otuafi began working as an NP in the CMDHB renal service two years ago. This followed more than 15 years' renal experience,

including as a renal nurse specialist and working as a charge nurse or acting charge nurse manager. "The beauty of working in the renal service is there are so many opportunities to move within the service," she said. "I worked on the ward for 10 years, then moved to the acute dialysis unit, home therapies, and now mostly work with chronic kidney disease (CKD), renal supportive care and pre-dialysis patients in the community." CMDHB supported Otuafi to complete her postgraduate diploma in 2013, then her Master of Nursing two years later. Having completed her NP qualification, she is finding she is missing studying. "It really has become my major hobby in life," she said. Otuafi is one of two NPs employed in the renal service. She and Angela Jackson run weekly hypertension and CKD clinics in all of the DHB's localities – Otara, Mangere, Botany, Manukau Super clinic and Pukekohe.

The NPs each run three or four clinics per week, seeing between six and eight patients during the half-day sessions. Otuafi also runs after hours clinics in the weekends and the evenings for patients who are working during normal clinic hours. The NPs will see those too sick to get to a clinic in their own homes or residential care facilities. "We see patients who are at risk of developing CKD and have other long-term conditions that cause kidney disease such as diabetes and hypertension," Otuafi said. "We will see them fortnightly or monthly and later discharge them back to a GP, once we have established clear treatment plans for them.

"Improving our patients' access to health services is our key priority. Another is having the time to educate them about their conditions, medications and lifestyle modifications. We want to support them to take ownership of their own health, as well as managing/monitoring their conditions in the community. "We will discuss treatment options with them. What these patients want is some flexibility, the ability to keep working and participating in the community, especially attending church and family gatherings. "It takes time for patients living with CKD to accept they have kidney disease. You have to have lots of patience and the passion to go the extra mile for these patients."

A kidney transplant is obviously the best option, but unfortunately finding donors can be hard, and many patients or their family members will have other co-morbidities that make having a transplant or donating a kidney very complicated.

Dialysis and haemodialysis are the next options. If they can have these procedures done at home, they will have better quality of life and long-term outcomes. However, for many Pacific people, their housing is already overcrowded, and they will often be in rental properties, which makes it hard for them to have a dialysis machine at home. The costs of running the machine in terms of their water and electricity bills may also create barriers for them to do their own dialysis at home.

There are around 640 patients on dialysis at CMDHB, with more than 60 per cent identifying as Maori and/or Pacific. "Some patients will choose conservative management rather than dialysis. Dialysis is only to prolong life – it does not cure the disease. Therefore, dialysis may not be a suitable option for some patients, especially older patients or patients with other incurable/complex diseases." Otuafi struggles to

convince some patients how serious their disease can be. Kidney disease is a silent disease, she says, as most people will feel fine until their kidney is about to stop working is ready to go the extra mile Fakaola Otuafi's first experience nursing patients with renal disease was as a student. Despite the complexities of this area of practice, her passion remains undimmed.

Otuafi also runs bimonthly multidisciplinary team meetings with a focus on renal supportive care (ie caring for patients not on dialysis). These meetings will include social workers, occupational therapists, a senior medical officer, hospice staff and GPs. Managing people with end-stage kidney disease is difficult and complex, she says. "At the later stages of their disease, we will be preparing them for renal replacement therapy, and managing other chronic conditions associated with kidney disease and CKD symptoms. You need the time and good therapeutic/trusting relationships to manage these patients – a lot more time than a 15-minute appointment."

Advance care planning (ACP) is also part of Otuafi's role in the renal service. All dialysis, pre-dialysis and renal supportive care patients have their first conversations about ACP, either in a clinic with their renal physician, during their pre-dialysis education or at the renal supportive care clinic. "I am amazed how many patients have already begun thinking about how and where they should document their end-of-life cares," Otuafi said. "Part of our everyday nursing practice is to discuss and review our patients' ACP if they already have one. Because we have already built trusting relationships with them, we find it very easy to discuss ACP with them and their families. Other opportunities to discuss an ACP is when we see them three times a week at the dialysis units." Otuafi gains a great deal of satisfaction from being able to provide people with what they want at the end of their lives, helping them achieve what matters most to them. If that wish is to die at home, for example, she can ensure they get all the help and support they need to achieve that. "I also support a patient's family to understand the process and what to expect when their loved one moves to conservative management. I can alleviate any anxieties the family may have and, in this way, make a real difference to them and my patients."

Otuafi is the only Tongan NP in New Zealand and the only Pacific NP at CMDHB. Around eight per cent of CMDHB nurses are Pacific. This is much higher than the proportion of Pacific nurses nationally – around three per cent – but still well below the numbers the DHB would like to achieve. "For most people, becoming a nurse manager or educator seems the only logical progression in a nursing career," Otuafi said. "However, this can sometimes be due to a lack of awareness of the NP pathway and the availability of the NP role."

Otuafi knows the challenges involved in getting onto an NP pathway and how much support is needed from the DHB and medical staff for that to happen. Also, opportunities to become an NP do not present themselves that often. "More clinical nursing expertise is what Pacific people need and is what can make a real difference to their health. As a renal nurse specialist, I became very frustrated doing patient assessments, then having to wait for the doctor to write the prescriptions. I wanted to get the job done in one go – to arrange for the diagnostic testing and to write the prescriptions as well. Being able to complete all these steps now makes me feel I have fulfilled my responsibilities as a clinician – I can provide all the care my patients need." Otuafi's passion for Pacific health, particularly for renal patients, has been well recognised in recent years. In 2016, she received two awards – the Pacific nursing award at CMDHB and the Renal Society of Australasia symposium award for the best oral presentation. That same year she received her Master of Nursing with first class honours from the University of Auckland (UoA). This year, the University of Auckland awarded both her and Jackson with a leadership/innovation award in recognition of their work with NP interns at the university. Otuafi and Jackson have also lectured pharmacist students on CKD.



Fakaola Otuafi, Ngoi Eaio, Angela Jackson, CMDHB award winning renal nurses.

Otuafi's work is not just confined to Auckland. Recently, she went to Tonga to help conduct "a gap and competence analysis" of nurses there, funded by New Zealand's Ministry of Foreign Affairs. "It's always good to go back to my home and offer any help I can," she said. Otuafi's three children, aged 14, 12 and nine, still wonder why she has no homework to do – they have been so accustomed to their mother seeking

peace and quiet, so she can get on with her studies. "I have too much time on my hands at the moment. Even though my home and work lives are busy, I have learnt to fit study in with whatever time I have. The great thing is being able to do so much research online these days and not having to go to the library to look for resources." Otuafi intends beginning her PhD studies next year. Her topic will be an integrated secondary and primary health care model for managing CKD for Pacific people in the Auckland region.

And from our Fundraiser

Ways to support Kidney Health New Zealand:

1. Follow us on Facebook, Twitter or Instagram.

Your support on these platforms is a social proof that we are meaningful and the work we do is important. You influence others and boost our reach into the wider world. That means we can help more people. Please like, share and comment on our posts, or post a picture and note on social media about your experience with kidney health, or Kidney Health New Zealand. Want to follow KHNZ? Search Kidney Health New Zealand on Facebook, Twitter.

2. Forward our emails to a friend to help build a new connection.

You know a wealth of people who all have spheres of influence, share our newsletter with someone who you think might get something from it. They could be a business owner or someone who you think might benefit from the information from Kidney health. These connections unlock new possibilities. Next time you get our newsletter or an email from us, consider: Who in your circle needs to know about these resources or initiatives?

3. Email us a story about your experience with kidney health.

We spend a lot of hours and passion into raising awareness of Kidney health. Sometimes a human story about life with kidney disease or living with a kidney patient can inspire and motivate us to new heights. Your experience might even become a powerful testimony that helps us spread the word about kidney disease. It might encourage someone to get tested and catch kidney disease in the early stages.

4. Volunteer a few hours of your time and expertise.

Kidney health month is March 2019. Get in early and register your interest to help and raise awareness during this month. Do you have a special skill or interest area that could help us? Let us know! Send a quick email to explain your idea and area of expertise. We appreciate all suggestions.

5. Donate to Kidney Health.

You can donate using the form below:

Yes, I want to help in the fight against Kidney Disease and support Kidney Health New Zealand!

I/we would like to donate: ☐ \$100 ☐ \$50 ☐ \$30 ☐ Other: _____

Payment type: ☐ Cheque (made payable to Kidney Health NZ) ☐ Mastercard ☐ Visa

Card number:

Card expiry date: / / Name on card: _____

I would like: ☐ A receipt for my donation ☐ Information about gifting to Kidney Health in my will

☐ Information about kidney donation/transplants ☐ To become a member of Kidney Health NZ

Name: _____

Address: _____

Please return this form to Kidney Health New Zealand, PO Box 20072, Bishopdale, Christchurch.