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FORUM OF ESRD NETWORKS/THE NATIONAL KIDNEY FOUNDATION
UNIFORM ESRD TRANSIENT HEMODIALYSIS FORM

PATIENT INFORMATION

Patient Name: _____ DOB __/__/__ Sex_Marital Status_____ ____
Last First
Parent or Legal Guardian (If Minor)_____

Address: _____ Phone: (H) _____(W)_____

SSN# _____ HIC# _____ Date of first Dialysis ____/____/____

ESRD Diagnosis: Primary _____ Secondary_____

Treatment Dates Requested __/__/__-__/__/____ Total # of Treatments_____

Preferred Time:_____

REFERRING DIALYSIS UNIT INFORMATION

Referring Unit Name _____ Phone _____ Fax_____

Contact Nurse _____ Social Worker _____

Primary Nephrologist _____ Phone _____ Fax_____

Emergency Pt. Contact Name_____Relationship_____Phone (H) _____

Phone (W)_____

LOCAL RESIDENCE INFORMATION (TRANSIENT CITY)

Local Address or Hotel _____ Phone_____

Emergency Contact _____ Relationship _____ Phone_____

Admitting Nephrologist _____ Phone_____

CURRENT TREATMENT ORDERS

_____ Home _____ In-Center Hemo _____ Self Care _____ Staff Assisted

Dialyzer: _____ Reuse? ___Yes ___ No Blood Flow_____ Dialysate Flow _____

_____

Treatment Type_____ Conventional_____ High Flux_____ High Efficiency Volumetric _____Yes _____No

Times Per Week _____ Prescribed Time _____

Dialysate Rx: K+_____ CA++_____ Dextrose_____ Sodium_____ Bicarb_____ Acetate_____

Sodium Modeling: _____

Dry Weight _____#kg _____#lb

Heparinization Method _____ Total Units_____

If pump, DC _____hr/min. pretreatment termination

VASCULAR ACCESS

Vascular Access: Type _____ Location_____ Flow Direction_____

Local Anesthetic ___ Yes ___ No Usual Venous Pressure_____ Diagram:_____

Other special cannulation considerations: i.e., needle gauge, self-cannulation _____

_____

_____

Vascular catheter special flush instructions _____

_____

_____

PATIENT SPECIFIC INFORMATION:
(SYNOPSIS OF UNIQUE CHARACTERISTICS OF PATIENT'S TREATMENTS)

Allergies:_____

Patient's trends and usual response to treatment_____

Inter dialytic wt. gains_____# kg B/P range: Pre_____Intradialytic_____Post_____

Usual BP support methods_____

_____

_____

Unusual reactions or need_____

_____

Special needs or circumstances relative to transient visit_____

_____

_____

INTRADIALYTIC MONITORING: IF APPLICABLE, OTHERWISE NOTE "N/A"

Special Labs_____ Blood glucose_____

Intradialytic treatments: Dressings_____ O2 _____Other_____

EPO _____Yes _____No_____Units_____SQ _____IV_____x's/week

Calcijex _____Yes _____No _____ Mcg _____X's/Week

Intradialytic meds: (i.e., Infed)_____

Mobility:_____Ambulatory _____Non-Ambulatory_____Ambulatory with assist

Special Dietary Considerations_____

Intradialytic Nutrition Orders_____Fluid Restriction_____

ENCLOSURES: CHECK INDICATES INFORMATION SENT FROM HOME FACILITY

_____ Standing Orders _____ Advance Directive, if applicable

_____ Problem list (Last 6 months) _____ Current H & P (within 1 year)

_____ Medication record (home and in-center) _____ Hemo last 3 treatment records

_____ Most recent psycho-social evaluation _____ Long-term care plan (current year)

_____ Patient care plan (most recent within 6 months) _____ Most recent nutritional assessment

_____ Progress note (past 3 months to current) _____MD_____RN_____RD_____MSW

_____ Diagnostic tests:_____EKG _____CXR (within 2 years) _____Laboratory profile (within last 30 days)

_____ HBsAg status____Positive____Negative Date ____/____/____

_____ HbsAB status ___Positive____Negative Date ____/____/____ Vacine series complete___Yes ____No

_____ Insurance information, carrier name & address current copies (front & back) of the following:

_____ Medicare card _____ Co-insurance card(s) _____ other (specify)_____

TRANSPLANT LIST INFORMATION (IF APPLICABLE) FOR SEASONAL PATIENTS ONLY

_____LRD_____Cadaver

Transplant facility name and address_____

_____

_____

Contact Person _____ _____Phone_____

SPECIAL INSTRUCTIONS

_____

_____

_____

_____

PATIENT IS NOT ACCEPTED UNTIL OFFICIAL NOTICE IS RECEIVED FROM RECEIVING UNIT.

Signature_____Title_____Date ____/____/____

(Referring unit person who completes form)

FORUM OF ESRD NETWORKS/THE NATIONAL KIDNEY FOUNDATION
UNIFORM ESRD TRANSIENT PERITONEAL DIALYSIS FORM

PATIENT INFORMATION

Patient Name_____DOB ___/___/___ Sex____ Marital Status _____
Last First

Parent or Legal Guardian (IF Minor)_____

Address _____Phone (H)_____(W)_____

SS# _____HIC#_____ _____Date of first Dialysis ___/___/___

ESRD Diagnosis: Primary _____Secondary_____

Date of Arrival ___/___/___ Date of Departure ___/___/___

REFERRING DIALYSIS UNIT INFORMATION

Referring Unit Name _____Phone _____Fax _____

Contact Nurse _____Social Worker _____

Primary Nephrologist _____Phone _____Fax _____

Emergency Patient Contact Name_____Relationship_____Phone (H) _____

Phone (W)_____

LOCAL RESIDENCE INFORMATION (TRANSIENT CITY)

Local Address or Hotel _____Phone _____

Emergency Contact _____Relationship _____Phone _____

Admitting Nephrologist _____Phone _____

CURRENT TREATMENT ORDERS

____CAPD_____CCPD_____IPD_____Tidal _____In Center____Home Date Started ___/___/___

Dry Weight _____#/kg ___Empty ___Full

Type of System (or cycler) _____Connecting System _____

Catheter Type _____Episodes of peritonitis past 6 months _____

Peritonitis Protocol _____

_____

_____

Exit site care _____

Last tubing change date ___/___/___

List supply of medications patient has:

_____EPO Self-Administers: _____yes_____no _____Heparin

_____Antibiotic: Specify _____Other _____

Additives used: _____

CAPD

Exchange Volume_____Dialysate_____

Exchanges per day_____

CCPD

Cycles _____Night Volume _____Dialystate_____

Day Volume _____Dialystate _____Total volume_____

Fill time_____Dwell time _____Drain time_____

PATIENT SPECIFIC INFORMATION:
(SYNOPSIS OF UNIQUE CHARACTERISTICS OF PATIENT'S TREATMENTS)

Allergies: _____

Unusual reactions or needs: _____

_____

_____

Average B/P_____Mobility: _____Ambulatory _____Non-Ambulatory_____Ambulatory with assist

Special needs or circumstances relative to transient visit _____

_____

_____

Vascular access: _____Yes_____No Type:_____

Location:_____

SPECIAL DIETARY CONSIDERATIONS

_____

_____

_____

Fluid Restriction _____

ENCLOSURES: CHECK INDICATES INFORMATION SENT FROM HOME FACILITY

__Standing orders

__Advance Directive, if applicable

__Problem list (Last six months)

__Current H&P (within 1 year)

__Medication record (home and in-center)

__PD last 3 clinic records

__Most recent psycho-social evaluation

__Long term care plan (current year)

__Patient care plan (most recent within 6 months)

__Most recent nutritional assessment

__Copy of RX supply

__Copy of self EPO training sheet

__Progress note (past 3 months to current) _____ MD____RN_____RD____MSW

Diagnostic tests _____EKG _____CXR (within 2 years) _____Laboratory profile (within last 30 days)

__HbsAg status _____Positive ___Negative Date __/ /____ Vaccine Series Complete___yes___no

__HBsAB status____Positive___Negative Date _____/ / ___

__Insurance information, carrier name & address current copies (front & back) of the following

__Medicare card _____Co-insurance card(s)_____Other (specify)_____

_____Method I _____Method II

TRANSPLANT LIST INFORMATION (IF APPLICABLE) FOR SEASONAL PATIENTS ONLY

LRD _____Cadaver

Transplant facility name and address _____

_____

_____

Contact Person_____Phone_____

SPECIAL INSTRUCTIONS

_____

_____

PATIENT IS NOT ACCEPTED UNTIL OFFICIAL NOTICE IS RECEIVED FROM RECEIVING UNIT.

Signature_____Title_____Date: ___/___/_____

(Referring unit person who completes form)