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)