Uniform ESRD Transient Hemodialysis Form

(Note: This form can be used by traveling hemodialysis patients in order to facilitate the receipt of treatment)

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_____

Treatment Dates Requested: ___/___/___ - ___/___/___ Total # of TX: _____

Preferred Time: _____

REFERRING DIALYSIS UNIT INFORMATION

Reffering Unit Name: _____ Phone: _____ Fax: _____

Contact Nurse: _____ Social Worker: _____

Primary Nephrologist: _____ Phone: _____ Fax: _____

Emergency Pt. Contact Name: _____Relationship: _____ Phone (H): _____

(W): _____

LOCAL RESIDENCE INFORMATION (TRANSIENT CITY)

Local Address or Hotel: _____ Phone: _____ Fax: _____

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

TimesPer 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. pre treatment termination

VASCULAR ACCESS

Vascular Access: Type _____ Location _____ Flow Direction _____

Local Anesthetic: __Yes __No Usual Venous Pressure: _____ Diagram: _____

Other special cannulation considerations: (e.g., 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: _____

Interdialytic wt. gains: _____ #kg B/P range: Pre_____ Intradialytic _____ Post _____

Usual B/P 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 _____ O_2_____ Other_____

EPO: __Yes __No _____Units ____ SQ ____IV _____X's/Week

Calcijex: __Yes __No _____Mcg _____X's/Week

Intradialytic medications: (e.g., Iron): _____

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
___Problem list (last 6 months)
___ Medication record (home & in-center)
___ Most recent psychosocial evaluation
___ Patient care plan (most recent within 6 months)
___ Progress notes (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 ____/____/____
___ HCV status: ___Positive ___Negative Date ____/____/____
___ HIV status: ___Positive ___Negative Date ____/____/____
___ Insurance information, carrier name & address, current copies (front & back) of the following:
___ Medicare card ___ Co-insurance card(s) ___Other (Specify)_____

___ Advance Directive, if applicable
___ Current H&P (within 1 year)
___ Hemo last 3 treatment records
___ Long-term care plan (current year)
___ Most recent nutritional Assessment

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)