The Virgin Islands Kidney Center

A division of

HealthQuest

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Transient Hemo-Dialysis division form

Patient Information

Patient Name: ________________________DOB__/__/__Sex ______
Last/First Marital Status:____
Parent or Legal guardian (if minor) ____________________________
Mail Address _______________________________Phone___________
SS#______________________HIC#__________________
Date of first Dialysis__/__/___ESRD Diagnosis_____, _______,_____
Treatment Dates Requested:__________________________________

Referring Dialysis Unit Information

Referring Unit Name______________________Phone/Fax___________
Contact Nurse______________________Social Worker_____________
Primary Nephrologist________________Phone/Fax________________
Emergency Patient Contact Name_________________
Relationship____________Phone(H)____________(W)____________

Local-Residence Information (Transient City)

Local Address or Hotel_______________________Phone__________
Emergency Contact_____________Relation______Phone__________
Admitting Nephrologist______________________ Phone__________

Current Treatment Orders

_____In Center Hemo _____Home _____Self Care_____Self Assisted
Dialyser__________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 _______#Lbs
Heparinization Method_________________Total Units___________
If Pump, DC_________________hr/min per treatment termination

Vascular Access

Vascular Access: __________Type Location________Flow Direction_________
Local Anesthetic____Yes___No Usual Venous Pressure______Diagram_______
Other special cannulation consideration: ie., needle gauge, self cannulation
____
Vascular catheter special flush instructions______________________________
____
____

Patient Specific Information:
(Synopsis of Unique Characteristics Of Patient's Treatment)

Allergies: ____
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, if otherwise note "N/A"

Special Labs_______________________Blood Glucose____________
Intradialytic treatments: Dressing___________02_______________
Other______
EPO ___Yes___No Units_______SQ_____IV________x's/week____
Zemplar___Yes___No _____Mcg_______x's/week
Intradialytic meds: (i.e., Venofer)______________________________
Mobility________
Ambulatory___Non-Ambulatory___Ambulatory w/assistance___

_Special Dietary Considerations: _________________________
____
Intradialytic Nutrition Orders_________________________________

Enclosures: Check indicates information sent from Home Facility

__Standing Orders
__Problem List (last 6 months)
__Medication Record
__Most Recent psycho-social evaluation
__Long Term Care Plan (Current Year)
__Patient Care Plan (most recent w/in 6 months)
__Most recent Nutritional Assessment
__Progress Notes (past 3 months to current)__MD__RN__RD__MSW
__Diagnostic Test __EKG__CXR(w/in 6 months)
__Laboratory Profile(w/in last 30 days)
__HbsAg ___HbsAB ___HEP C (With in 30 days)
___Vaccine Series Complete __Yes __No
__ Advance Directive, if applicable
__ Current H/P (with in one year)
__ Hemo Last 3 Flow Sheets
___ 2728 Form
___ Demographics Sheet
___ Copy Insurance Cards (Both sides)

Insurance Information

Carrier Name & Address____________________________________
____
Current Copies (front & back) of the following:
__Primary Insurance__Medicare Card__Secondary Insurance__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)