

Transient Dialysis Form (3 pages)

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 ***Required to forward to IHS**

____ Diagnostic tests: ____ EKG ____ CXR (within 2 years) ____ Laboratory profile (within last 30 days)*

____ HBsAg status* ____ Positive ____ Negative Date ____/____/____

____ HbsAB status* ____ Positive ____ Negative Date ____/____/____ Vaccine series complete ____ Yes ____ No

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

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

***Required to forward to IHS**

HOLIDAY TREATMENT DATES

From _____ To _____

SPECIAL INSTRUCTIONS

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

Signature _____ Title _____ Date ____/____/____

(Referring personnel who completes form)