U.S. RENAL CARE

FORM : HEMODIALYSIS TRANSIENT FORM		EFFECTIVE DATE: 01/2011
POLICY # C-FORMS-0050	PAGE 1 OF 2	REVISION DATE: 12/2014

PATIENT INFORMATION

Patient Name: _____ DOB: __/__/____ Sex_____ Marital Status_____
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 Height_____in_____cm
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 _____

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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 _____

_____

_____

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_____

_____Standing Orders _____Advance Directive, if applicable _____2728

_____Problem list (Last 6 months) _____Current H&P (within 1 year)

_____Medication record (home & 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) _____ PPD Date _____/___/____ _____Laboratory Profile (within last 30 days)

_____HBsAg w/i past 30 days ____Positive____Negative Date _____/___/____ Vaccine series complete ___Yes___No

_____HBsAb w/I past year_____Immune_____Susceptible HBcAb (no time limit)____Positive____Negative

_____HCV w/i past 6 months_____Positive_____Negative

_____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)