St Lucia Vacation Dialysis Clinic

Transient Dialysis Form (3 pages)

PATIENT INFORMATION

Patient Name____ Sex: M / F______
Last First

DOB:_____/_____/_____ Marital Status_________________ Phone: (H)_____________ ___(W)__________________

Parent or Legal Guardian (If Minor):____

Address: ____

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

Local Address or Hotel ____

Phone______________________

Local 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 ______________

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CURRENT TREATMENT ORDERS (CONTINUED)

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

(SPECIFICS 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 ____________________

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INTRADIALYTIC MONITORING: IF APPLICABLE, OTHERWISE NOTE "N/A" (continued)

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 St Lucia Dialysis**

_____ 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 St Lucia Vacation Dialysis**

VACATION 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)

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