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Frost Valley/Gottscho Kidney Camp
UNIFORM ESRD TRANSIENT HEMODIALYSIS FORM

PATIENT INFORMATION

Patient Name:_____ _/_/_ Sex ___
Last First DOB
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 _____

LOCAL RESIDENCE INFORMATION (TRANSIENT CITY)

Local Address or Hotel Frost Valley YMCA/Ruth Gottscho Dialysis & Children's Kidney Program Phone 845-985-2291

Emergency Contact_____ Relationship_____ Phone_____

Admitting Nephrologist Kaskel Phone 718-665-1120

CURRENT TREATMENT ORDERS

_____Home _____ In-Center Hemo _____ Self Care _____ Staff Assisted

Dialyzer: _____ 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

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:
(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_____
_____
_____

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

_____ Diagnostic tests:_____EKG _____CXR (within 2 years)_____ Laboratory profile (within last 30 days)

_____ HBsAg status____Positive____Negative Date____/____/__

_____ HbsAB status ___Positive____Negative Date ____/____/__ Vacine series complete___Yes ____No

_____ 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)

Frost Valley/Gottscho Kidney Camp
UNIFORM ESRD TRANSIENT PERITONEAL DIALYSIS FORM

PATIENT INFORMATION

Patient Name_____DOB___/___/___ Sex____ Marital Status _____
Last First

Parent or Legal Guardian (IF Minor)_____

Address_____ Phone (H)_____ (W) _____

SS#_____ HIC#_____Date of first Dialysis ___/___/___

ESRD Diagnosis: Primary_____Secondary_____

Date of Arrival ___/___/___ Date of Departure___/___/___

REFERRING DIALYSIS UNIT INFORMATION

Referring Unit Name_____Phone _____Fax_____

Contact Nurse_____ Social Worker_____

Primary Nephrologist_____ Phone_____Fax_____

Emergency Patient Contact Name_____Relationship_____ Phone _____

LOCAL RESIDENCE INFORMATION (TRANSIENT CITY)

Local Address or Hotel Frost Valley YMCA/Ruth Gottscho Dialysis & Children's Kidney Program Phone: 845-985-2291

Emergency Contact_____Relationship _____ Phone_____

Admitting Nephrologist Kaskel Phone: 718-655-1120

CURRENT TREATMENT ORDERS

___CAPD_____CCPD _____In Center____Home Date Started ___/___/___

Dry Weight_____ #/kg ___Empty ___Full

Type of System (or cycler)_____Connecting System_____

Catheter Type_____ Episodes of peritonitis past 6 months_____

Peritonitis Protocol _____

_____

_____

Exit site care _____

Last tubing change date ___/___/___

List supply of medications patient has:

____EPO Self-Administers: _____yes_____no ___Heparin

____Antibiotic: Specify_____Other_____

Additives used: _____

CAPD - Camp Prescription

Exchange Volume_____Dialysate_____

Exchanges per day_____

CCPD - Home Prescription

Cycles_____ Night Volume_____Dialysate_____

Day Volume_____ Total volume_____

Fill time_____ Dwell time_____ Drain time_____

PATIENT SPECIFIC INFORMATION: (SYNOPSIS OF UNIQUE CHARACTERISTICS OF PATIENT'S TREATMENTS)

Allergies: _____

Unusual reactions or needs: _____

_____

_____

Average B/P_____Mobility: _____Ambulatory _____Non-Ambulatory_____Ambulatory with assist

Special needs or circumstances relative to transient visit _____

_____

_____

Vascular access: _____Yes_____No Type:_____

Location:

_____

SPECIAL DIETARY CONSIDERATIONS

_____

_____

_____

Fluid Restriction_____

ENCLOSURES: CHECK INDICATES INFORMATION SENT FROM HOME FACILITY

__Standing orders

__Advance Directive, if applicable

__Problem list (Last six months)

__Current H&P (within 1 year)

__Medication record (home and in-center)

__PD last 3 clinic records

__Most recent psycho-social evaluation

__Long term care plan (current year)

__Patient care plan (most recent within 6 months)

__Most recent nutritional assessment

__Copy of RX supply

__Copy of self EPO training sheet

__Progress note (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 __/__/___

__Insurance information, carrier name & address current copies (front & back) of the following

__Medicare card _____Co-insurance card(s)_____Other (specify)_____

_____ _____ Method

Method I II

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)