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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 ____

____

____

UNIFORM ESRD TRANSIENT HEMODIALYSIS FORM - PAGE 2

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

_____ Problem list (Last 6 months)

_____ Medication record (home and in-center)

_____ Most recent psycho-social evaluation

_____ Patient care plan (most recent within 6 months)

______ Advance Directive, if applicable

______ Current H & P (within 1 year)

______ Hemo last 3 treatment records

______ Long-term care plan (current year)

______ 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
__ Problem list (Last six months)
__ Medication record (home and in-center)
__ Most recent psycho-social evaluation
__ Patient care plan (most recent within 6 months)
__ Copy of RX supply
__Advance Directive, if applicable
__ Current H&P (within 1 year)
__ PD last 3 clinic records
__ Long term care plan (current year)
__ Most recent nutritional assessment
__ 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 I ________ Method II

TRANSPLANT LIST INFORMATION (IF APPLICABLE) FOR SEASONAL PATIENTS ONLY

LRD_____Cadaver
Transplant facility name and address ____________________

____

____

Contact Person____________________Phone____________________

SPECIAL INSTRUCTIONS

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Signature____________________Title__________________Date:___/___/______
(Referring unit person who completes form)