

FORUM OF ESRD NETWORKS/THE NATIONAL KIDNEY FOUNDATION  
UNIFORM ESRD TRANSIENT HEMODIALYSIS FORM

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ DOB / / Sex \_\_\_\_\_ Marital Status \_\_\_\_\_  
Last First  
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  
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 _____ / _____ / _____ 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) _____	

**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)