



**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**

- |   |  |
|---|--|
| <input type="checkbox"/> Standing orders  | <input type="checkbox"/> Advance Directive, if applicable          |
| <input type="checkbox"/> Problem list (Last six months)   | <input type="checkbox"/> Current H&P (within 1 year)               |
| <input type="checkbox"/> Medication record (home and in-center)   | <input type="checkbox"/> PD last 3 clinic records                  |
| <input type="checkbox"/> Most recent psycho-social evaluation   | <input type="checkbox"/> Long term care plan (current year)        |
| <input type="checkbox"/> Patient care plan (most recent within 6 months)  | <input type="checkbox"/> Most recent nutritional assessment        |
| <input type="checkbox"/> Copy of RX supply  | <input type="checkbox"/> Copy of self EPO training sheet           |
| <input type="checkbox"/> Progress note (past 3 months to current) _____ MD _____ RN _____ RD _____ MSW                |  |
| Diagnostic tests _____ EKG _____ CXR (within 2 years) _____ Laboratory profile (within last 30 days)                  |  |
| <input type="checkbox"/> HbsAg status _____ Positive _____ Negative   | Date ____ / ____ / ____ Vaccine Series Complete _____ yes _____ no |
| <input type="checkbox"/> HBsAB status _____ Positive _____ Negative   | Date ____ / ____ / ____  |
| <input type="checkbox"/> Insurance information, carrier name & address current copies (front & back) of the following |  |
| <input type="checkbox"/> Medicare card _____ Co-insurance card(s) _____ Other (specify) _____                         |  |
| <input type="checkbox"/> Method I _____   | <input type="checkbox"/> Method 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)