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DIALYSIS UNIT VISITING PATIENT FORM

INSTRUCTIONS:
Please complete this form and return to the Central Florida Kidney Center by _____. Transient dialysis will be confirmed for your patient AFTER receipt of **this completed form and ALL** required copies of information.

PATIENT INFORMATION

Name _____ DOB _____Age _____

Home Address _____

_____Home Contact number_____

SSN _____Primary Insurance _____

Secondary Insurance_____ Billing Phone_____ Home Unit Contact_____

Address while visiting the Orlando area_____

_____Phone in Florida_____

How will the patient transport to the dialysis facility? Self ☐ Family ☐ Public Service ☐ Stretcher ☐ Other_____

Treatment dates Requested _____

Emergency Contact Name and Number _____

B. REFERRING HOME DIALYSIS UNIT: _____

Referring Doctor: _____contact number:_____

Dialysis Unit Address _____

Phone _____Contact Person at your unit _____Extension: _____

DIALYSIS INFORMATION

Access type and location: _____

Dialyzer _____Reuse ? _____Dialyzer Allergies?_____Presenting Symptoms_____

Dialysis Frequency _____/ week, Length of treatment _____Lines - Adult_____ or Peds – Size _____

Dialysate: Na _____ K+ _____ Ca _____ Blood flow_____ Dialysate flow rate_____

Needles size _____ (Lidocaine not stocked or used at CFKC)

Dry Weight_____ Kg_____Lbs. Height _____ cm

Heparinization: Beef or Pork
Initial _____ units, Maintenance _____ units. Total Heparin Amt. _____

If Catheter access, dwell type and amount: Arterial port_____Vein port_____

Average PRE treatment BP_____ Average POST treatment BP _____ Average weight gain between dialysis _____

Intradialytic Problems/Comments_____ _____

_____

Patient Name_____SSN_____

DIALYSIS MEDICATION DOSAGE:

_____

_____

_____

_____

_____

PATIENT MEDICAL INFORMATION

Primary diagnosis_____

Secondary diagnosis_____

Comorbid conditions_____

Date of initial dialysis_____

Diet: _____ Protein _____ Na _____ K _____

24 hour fluid restriction _____ URR and Kt/v_____ Date _____

Patient Hepatitis B result/date _____Patient HBsab result/date_____titer_____

Has patient completed Hepatitis B vaccine?_____

Patient TB test type/ result/date_____CXR clear for TB?_____

Date of Flu vaccine_____Date of Pneumovax Vaccine_____

HIV Treating Physician:_____Contact Number_____

Last blood transfusion _____ (WRBC, PRBC, FRBC,WHOLE BLOOD) _____

Is the patient a transplant candidate?_____

Transplant facility name and phone number: _____

Diabetic? NO__○____YES_○_____TYPE_____Insulin dependent?_____

Surgery in the last 12 months?_____

Infections in the past 12 months?_____

Medication allergies _____

Primary Language _____ Speaks English fluently? Yes ○no ○Will bring translator for dialysis_____

Independently Ambulatory: yes ○ no ○ Uses Wheelchair □ Cane □ Walker □ artificial limb □ ___

Is patient able to independently transfer in and out of dialysis chair? Yes ○No ○
Assistive transfer Equipment type_____

Visually impaired? Yes ○ No ○ Wears glasses? Yes ○ No ○ Hearing impaired? Yes ○ No ○ Uses Hearing Aid? Yes ○ No ○

Other Special Needs?_____

Patient Name_____SSN_____

REQUIRED INFORMATION:
Please share our billing policies and requirements with your patient so they will be well informed, and have ample time to ask questions.

1. List of home medications with dosage/frequency.
2. Legible copy of Medicare Card and all other applicable insurance cards (front and back).
3. Determination of patient financial responsibility will be made upon receipt of this form, validation of insurance coverage and treatment authorization from carrier. Without insurance authorization, patient will be responsible for full bill rate for services.
4. History and Physical within past 12 months.
5. Copies of recent monthly labs
6. **HbsAg** done within FOUR WEEKS OF ARRIVAL if patient is **susceptible** (HbsAb negative).
   HbsAb done within 12 MONTHS if patient is **HbsAb positive** and titer is ≥ 10 S.R.U.
   URR and Kt/v done within FOUR WEEKS OF ARRIVAL and lab copy on file here prior to patient arrival.
7. Copy of most current EKG, and CHEST X-RAY within last 12 months.
8. Three most recent dialysis treatment sheets now for review and additional current to be hand carried with patient.
9. **Pediatric patients,** physician office visit agreement letter, completed and returned.
10. All transfers or visitors here longer than one month will also require:
    Copy of SSA 2728 form
    Copy of Psycho Social History
    Copy of Nutritional Assessment
    Copy of Comprehensive Care Plan

We are here to serve and your patient may want to know the following information before their arrival. Please share this information in advance with your patient.

We do not stock or use Lidocaine or similar products to use with cannulation of the access. We do not stock pain medications, other than Tylenol. If other pain medication is needed, the patient would need to bring their own prescription medication.

For safety reasons, patients may not bring medication to the dialysis unit for nurses to administer during their visit . Arrangements would need to be made for a pharmacy to ship any special IV medication that we do not stock.

The patient may bring a snack to the dialysis treatment that does not require heating or refrigeration. Water is available to drink.

We do not allow visitors in the adult dialysis unit without permission from the Charge Nurse and visiting time is limited. Pediatric patients must have a parent or guardian on campus during the dialysis treatment. Siblings of visitors must have an adult in attendance at all times and may be seated in the reception area.

There is a TV available in the reception area. Wi Fi is available with a pass code from the receptionist.

The patient should wear comfortable clothing and bring a lap cover or small blanket if there is a tendency to be cold.

Form Completed by (Name and Title)_____Date_____

Please note our mailing address is

203 Ernestine St. Orlando, FL 32801

Fax: 407-425-1125