

DIALYSIS MANAGEMENT CLINICS, INC.
(Markham, Pickering, Peterborough)

PATIENT TRANSFER RECORD

Patient Information

Name: _____
Address: _____
Phone (home): _____ (work): _____ (cell): _____
Health Card Number: _____ Version Code: _____
Date of Birth (month/day/year): _____ Male / female (circle please)
Allergies: _____
Primary diagnosis/cause of renal failure: _____
Date of first dialysis treatment (M/D/Y): _____ Type: _____
Next of Kin (name): _____ (relationship): _____ (#): _____
Family Physician (name): _____ (#): _____
Pharmacy (name): _____ (#): _____
Blood Group: _____
M.O.R.E. #: _____ Hospital listed with: _____
Mobility (ambulatory, uses cane, wheelchair, etc.): _____
Languages spoken: _____

Referring Dialysis Unit Information

Referring Hospital: _____ Name of person completing forms: _____
Referring Nephrologist (name): _____ (#): _____
Nephrologist who will be responsible for ongoing care (if different than above): _____
If nephrologist does not have any patients at DMC, please provide the following information:
Physician billing #: _____ Office Address: _____
Phone #: _____ Fax #: _____ Pager #: _____

Vascular Access Information

Vascular Access Type: _____ Location: _____
Central catheter insertion type & insertion date: _____
Dressing type: _____ Length: (A) _____ (V) _____
Fistula / Graft creation date: _____ Access blood flow: _____
Average arterial pressure: _____ Average venous pressure: _____
Relevant history (e.g. declothing, revision, stenosis, etc.): _____

Treatment Information

Average interdialytic weight gain: _____ Max. fluid removal: _____
BP range: (pre) _____ (intra) _____ (post) _____
Complications during dialysis: _____

Special Instructions/Upcoming appointments/etc.

Enclosures (check indicates information is being sent)

- _____ DMC Dialysis Orders (signed by nephrologist)
- _____ DMC Medical Problem list (completed by nephrologist)
- _____ History & Physical
- _____ E.C.G. report (within last year)
- _____ Chest X-ray (within last year)
- _____ 3 most recent dialysis treatment records
- _____ transplant status info
- _____ Hepatitis B Vaccination schedule
- _____ HbsAg & Ab report (recent)
- _____ Advance Directives information if available
- _____ Monthly blood work results
- _____ MRSA & VRE reports (just prior to transfer)
- _____ TB skin testing (advised)
- _____ Medication List
- _____ Nutrition consult note
- _____ Social work consult note
- _____ Consent #1: patient consent
- _____ Consent #2: consent to release of health information
- _____ Consent #3: hospital agreement (must be signed by nephrologist)
- _____ Consent #4: temporary consent (if necessary---we will inform you)
- _____ First clinic appointment booked (n/a for Lakeridge & Peterborough patients)
- _____ Any other pertinent information/consults/reports/tests etc.

NOTE: once the information package has been received it will be reviewed by DMC. If the patient is accepted into the programme, the referring hospital will be contacted with a start date and time.

We will also ask that the home hospital send with the patient their supply of EPO/ Aranesp, Venofer, Calcijex, Engerix, and any I.V. antibiotics that may need to be administered.

