

PATIENT TRANSFER FORM

PATIENT INFORMATION

DATE:

NAME: _____ ADDRESS: _____ _____ PHONE # (H) _____ (W) _____ HEALTH CARD # _____ DIAGNOSIS: _____ BLOOD GROUP: _____ MOBILITY(ambulatory, wheelchair, etc.): _____	SEX: _____ DATE OF BIRTH: _____ NEXT OF KIN: _____ RELATIONSHIP: _____ PHONE #: _____ SOCIAL INSURANCE # _____ ALLERGIES: _____
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DIALYSIS INFORMATION

YEARS ON DIALYSIS: _____ VASCULAR ACCESS: _____ DIALYSIS: IN CENTER: _____ FREQUENCY OF TREATMENTS: _____ AVERAGE BLOOD FLOW: _____ HEPARIN: BOLUS (UNITS): _____ IDEAL WEIGHT: _____ COMPLICATIONS DURING DIALYSIS: _____ _____	LOCATION: _____ SELF CARE: _____ HOME: _____ LENGTH OF TREATMENT: _____ AVERAGE VENOUS RESISTANCE: _____ HOURLY INFUSION RATE (UNITS): _____ AVERAGE WEIGHT GAIN: _____ HEPARINIZATION OF CVL POST: _____ _____
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MEDICATION

MEDICATION	DOSE	MEDICATION	DOSE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

History and Physical	___	Hepatitis B Vaccination report	___	Dietary Note	
E.C.G. report	___	HbsAg Report	___	Social Work Note	___
Chest X-ray report	___	Monthly Chemistries	___	Release of Med. Info	___
3 Recent Dialysis Records	___	VRE, MRSA reports	___	Hospital Agreement	___
Other pertinent info.	___	TB testing (advised)	___	Patient Dialysis Consent	___
Transplant Status Info	___	Medical Problem List (advised)	___		
<u>Advance Directives discussed with patient</u>		YES		NO	

PLEASE SEND WITH THE PATIENT THEIR SUPPLY OF EPO, CALCIJEX AND ENGERIX.

REFERRING DIALYSIS FACILITY: _____ **PHONE NO:** _____

REFERRING DOCTOR'S SIGNATURE: _____ **DATE:** _____