Patient Summary Form

<u>Nursing Transfer Information:</u>

Patient Name:____

Patient DOB:___________ Height:_______ Weight:_______

Dates requested for dialysis:____________________________________

Current dialysis days: MWF:_____ TuThSat:_____ Other:____________

Hours on dialysis:_________

Access:___________________ Other access:______________

Location placed:____________ Location placed:____________

Date placed:_______________ Date placed:_______________

Dry weight:___________

Dialyzer:_____________ Reuse: Yes_____ No_____

Heparin Load:________ Heparin Maintenance:________ Type:________

BFR:______ DFR:______ Dialysate: K+______ Ca______ HCO3_____

Drugs:

Epogen:________ Frequency:_______ Other Drugs:_______________

Venofer:________ Frequency:_______ _________________________

Hectorol:________ Frequency:_______ _________________________

Labs:

Hepatitis B Ag Date Drawn:_________ Result:__________

Hepatitis B Ab Date Drawn:_________ Result:__________

Complications during dialysis:____

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Patient Summary Form

Special considerations:____

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Social Work Transfer Information:

Ambulates ____ Wheelchair ____ Walker ____ Cane ____

Primary Support Person _________________________________ Phone __________________

Primary Insurance _________________________________

Secondary Insurance ______________________________

Who pays insurance premiums?

Patient ____ AKF HIPP Program ____ SLMB, QMB ____

Transportation: _________________________ Phone _____________________

Comments/Follow-up Needed:

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Dietary Transfer Information:

SNF or assisted living Yes ____ No ____

Facility Name:_____________________ Contact:__________________

Nutritional Supplement Yes ____ No ____

Supplement Name:____

Comments/Follow-up Needed:

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