Commonwealth healthcare Corporation

Commonwealth of the Northern Mariana Islands

1 Lower Navy Hill Road Navy Hill, Saipan, MP 96950

Dialysis Unit
New Patient Intake Form

PATIENT INFORMATION

Patient Name _____ Marital Status _____ Sex: _____
Last First Middle

Parent or Legal Guardian (If Minor) _____

Birth Date _____ Age _____ Ethnicity _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Occupation _____ Employer _____ Employment Status _____

ESRD Diagnosis: Primary _____ Secondary _____

Date of First Dialysis ____/____/____ Treatment Dates Requested _____

Total # of Treatments _____ Preferred Time _____

REFERRING DIALYSIS UNIT INFORMATION

Referring Unit Name _____ Phone_____ Fax _____

Contact Nurse_____ Social Worker _____

Primary Nephrologist _____ Phone _____ Fax _____

IN CASE OF EMERGENCY

Emergency contact_____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

LOCAL RESIDENCE INFORMATION

CNMI Address or Hotel _____ Phone _____

Emergency Contact _____ Relationship to Patient_____ Phone _____

Admitting Nephrologist _____ Phone _____

CURRENT TREATMENT ORDERS

_____ Home _____ In-Center Hemo _____ Self Care _____Staff Assisted

Dialyzer _____ Reuse ___Yes ___No Blood Flow_____ Dialysate Flow _____

Treatment Type ____ Conventional ____High Flux ____ High Efficiency Volumetric ____ Yes ____ No

Times Per Week _____ Prescribed Time _____

Dialysate Rx: K+_____ CA++ _____ Sodium _____ Bicarb _____

Sodium Modeling _____

Dry Weight _____#kg

Heparin Loading Dose _____units Heparin Hourly Dose_____units

If pump, DC _____ hr/min. pretreatment termination

VASCULAR ACCESS

Type _____ Location _____ Flow Direction _____

Buttonhole ____ Yes ____ No Usual Venous Pressure _____

Other special cannulation considerations :(i.e., needle gauge, self-cannulation) _____

_____

Vascular catheter special flush instructions _____

_____

PATIENT SPECIFIC INFORMATION: *(Synopsis of Unique Characteristics of Patient's Treatment)*

Allergies _____

Patient's trends and usual respond to treatment _____

Inter dialytic wt. gains _____ #kg B/P range: Pre _____ Intradialytic _____ Post _____

Usual BP support methods _____

Unusual reactions or need _____

Special needs or circumstances relative to transient visit _____

INTRADIALYTIC MONITORING: *If applicable, otherwise note "N/A"*

Special Labs _____ Blood glucose _____

Intradialytic treatments: Dressings _____O2

EPO ____ Yes ____ No _____Units _____SQ _____IV _____x's/week

Hectorol/Zemplar ____ Yes ____ No _____Mcg _____x's/week

Intradialytic meds: (i.e., Infed) _____

Mobility: _____ Ambulatory _____ Non-Ambulatory _____ Ambulatory with assist

Special Dietary Considerations _____

Intradialytic Nutrition Orders _____ Fluid Restrictions _____

TRANSPLANT LIST INFORMATION (IF APPLICABLE) FOR SEASONAL PATIENTS ONLY

_____ LRD _____ Cadaver

Transplant facility name and address_____

_____

Contact Person _____ Phone _____

SPECIAL INSTRUCTIONS

_____

_____

_____

By signing below, I verify the above information to be true as ordered by the patient's attending physician.

Signature _____ Title _____ Date _____