BCRenal
Provincial Health Services Authority

Visiting Dialysis Patient Information

PATIENT INFORMATION LABEL

Name: _____

Address: _____

Phone: _____

PHN: _____

▶ Please fax (1) this form; (2) the *Checklist for Visiting Dialysis Patients*; and (3) *Visiting Dialysis History & Physical Update* form **within 2 weeks** of receiving this request. Dialysis reservations cannot be confirmed until the information has been reviewed by our nephrologist.

BC patients: Please attach the PROMIS Patient Registration Summary. Sections A and B do not require completion.

A) DEMOGRAPHIC INFORMATION	
Patient name:	Gender:
Birth date (DD/MM/YYYY):	
Home address:	
City:	Province/State:
Country	Postal/ZIP code:
Telephone (home):	Cell:
Emergency contact name:	
Address:	
Telephone (home):	Cell:
Provincial health # (if from within Canada)	Expiry date (DD/MM/YYYY):
B) HOME DIALYSIS UNIT INFORMATION	
Referring hospital (Unit):	
Telephone (include country + area code):	Fax (include country + area code):
Referring nephrologist:	
Telephone (include country + area code):	Fax (include country + area code):

C) PATIENT VISIT INFORMATION

Reason for visit: ◯ Vacation ◯ Medical Referral ◯ Business

Address while staying at destination:

Telephone:

Local contact person name: | Telephone:

Person arranging care : ◯ Self ◯ Other

If Other, Name: | Relationship:

Telephone (include area code): | Fax (include area code):

D) MEDICAL INFORMATION

Allergies:

Renal Diagnosis:

Diabetes mellitus: ◯ Yes ◯ No | Insulin dependent: ◯ Yes ◯ No

Other medical conditions:

Year of HD start:

E) CARE INFORMATION

Dialysis days:
☐ Mon ☐ Tues ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun

Language(s) spoken:

Mobility:
◯ Independent
◯ One person assist to transfer or reposition
◯ Two or more persons or mechanical lift to transfer or reposition
◯ Uses mobility aide(s), specify type(s): _____

Fall risk (specify):

Blood work required (type & frequency):

Code status: ☐ Refer to resuscitation directions (attached)

Is blood glucose monitoring required during the HD run? ◯ Yes ◯ No

F) DIALYSIS PRESCRIPTION								
Target weight								
Duration (hours/run)								
Frequency (#/wk)								
Maximum UF target								
Dialyzer	**Fresenius:**	☐ Fx600		☐ Fx800		☐ Fx1000		
	Cellentia:	☐ 19H		☐ 21H				
	Nephral:	☐ 400		☐ 500				
	Other: Type:			Membrane:				
Dialysate	K+							
	Ca							
	Na							
	Na Profile							
	HCO3							
	Dialysate flow (Qd)							
	Dialysate temp							
Medications as listed on the run sheet (e.g., Iron, ESAs)	Pre-dialysis							
	Intra-dialysis							
	Post-dialysis							
Heparin anticoagulant	Loading							
	Running (units/h)							
	Stop time							
	Heparin-free (or heparin substitute)							
Current vascular access	Type/site & side							
	Needle gauge							
	If CVC:							
	Locking agent							
	Type of dressing							
	Type of cleaning solution							
	If fistula/graft:							
	Topical or local anesthetic:	☐ Yes, specify: _____				☐ No		
	Arterial lumen							
	Venous lumen							

F) Special considerations (e.g., access cannulation information, preparation of dialyzer, patient to bring own dialyzer, patient to bring own needles, etc)