Transient Cover Sheet

When inquiring about a transient patient, please include the following information. It is very important that we receive this information in a timely manner in order to review it and schedule a time for the transient. For any questions or concerns, please contact:

Mary Liechty
Administrator
Mt. Pleasant, IA 52641
Phone: 319-385-6720
Cell: 319-931-0403

_____Copies of Insurance Cards
_____Patient Demographics
_____2728
_____History & Physical (within a yr. visit)
_____Current Labs (within 30 days of visit)
_____Hepatitis Status (within 30 days of visit)
_____Current Dialysis Orders
_____Current Medication List
_____Last 3 Flowsheets
_____Long & Short Term Care Plans
_____Physician Progress Notes (past 3 months to current)
_____Advanced Directives

Southeastern Renal Dialysis has five (5) units available to transients. These units are:

Southeastern Renal Dialysis—Mt. Pleasant
Phone: 319-385-6720 Fax: 319-385-6726
Southeastern Renal Dialysis—West Burlington
Phone: 319-758-0691 Fax: 319-758-0392
Southeastern Renal Dialysis—Ft. Madison
Phone: 319-372-7996 Fax: 319-372-7830
Southeastern Renal Dialysis—Keokuk
Phone: 319-524-2105 Fax: 319-524-2188
Southeastern Renal Dialysis—Fairfield
Phone: 641-469-3313 Fax: 641-469-3350

Please make sure all copies are legible before faxing to the appropriate unit. Thank you for all of your cooperation.

DIALYSIS PATIENT FINANCIAL POLICY/PROCEDURE

Southeastern Renal Dialysis, L. C.

Each patient requesting dialysis services at a Southeastern Renal Dialysis facility is required to forward all insurance information to the unit where dialysis will occur. This information will be reviewed by a member of the SRD team prior to the confirmation of treatments.

All charges for patients eligible for Medicare are submitted to Medicare for payment. If the patient has insurance, the business office will bill remaining charges/co-pays to the appropriate insurance company. If no additional insurance coverage is available, the patient will be responsible for the remaining balance. This amount will be determined and reviewed with the patient prior to the initiation of treatment.

Billing Information

Name		
Phone		
Address		Zip Code
Date of Birth		
Emergency Contact Name/Phone Address		
Medicare ID #		Effective Date
Medicaid ID # Effective Date		County and State
Other Insurance Policy # Name Address		Subscriber Name Effective Date

My signature below indicates that I understand and agree to comply with the above stated policy.

Signature _____ Date _____

FORUM OF ESRD NETWORKS/THE NATIONAL KIDNEY FOUNDATION
UNIFORM ESRD TRANSIENT HEMODIALYSIS FORM

PATIENT INFORMATION

Patient Name:_____ DOB__/__/__ Sex_____ Marital Status_____
Last First
Parent or Legal Guardian (If Minor)_____

Address:_____ Phone: (H) _____ (W)_____

SSN#_____ HIC#_____ Date of first Dialysis____/____/____

ESRD Diagnosis: Primary_____ Secondary_____

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_____

Emergency Pt. Contact Name_____ Relationship_____ Phone (H) _____

Phone (W)_____

LOCAL RESIDENCE INFORMATION (TRANSIENT CITY)

Local Address or Hotel_____ Phone_____

Emergency Contact_____ Relationship_____ 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++_____ Dextrose_____ Sodium_____ Bicarb_____ Acetate_____

Sodium Modeling:_____

Dry Weight _____#kg _____#lb

Heparinization Method_____ Total Units_____

If pump, DC_____hr/min. pretreatment termination

VASCULAR ACCESS

Vascular Access: Type _____ Location_____ Flow Direction_____

Local Anesthetic ___ Yes ___ No Usual Venous Pressure_____ Diagram:_____

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 TREATMENTS)

Allergies:_____

Patient's trends and usual response 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_____Other_____

EPO_____Yes_____No_____Units_____SQ_____IV_____X's/week

Calcijex _____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 Restriction_____

ENCLOSURES: CHECK INDICATES INFORMATION SENT FROM HOME FACILITY

_____ Standing Orders

_____ Problem list (Last 6 months)

_____ Medication record (home and in-center)

_____ Most recent psycho-social evaluation

_____ Patient care plan (most recent within 6 months)

_____ Progress note (past 3 months to current) _____MD_____RN_____RD_____MSW

_____ Diagnostic tests:_____EKG_____CXR (within 2 years)_____Laboratory profile (within last 30 days)

_____ HBsAg status____Positive____Negative Date ____/____/____

_____ HbsAB status ___Positive____Negative Date ____/____/____ Vacine series complete___Yes ____No

_____ Insurance information, carrier name & address current copies (front & back) of the following:

_____ Medicare card_____ Co-insurance card(s)____ other (specify)_____

_____ Advance Directive, if applicable

_____ Current H & P (within 1 year)

_____ Hemo last 3 treatment records

_____ Long-term care plan (current year)

_____ Most recent nutritional assessment

TRANSPLANT LIST INFORMATION (IF APPLICABLE) FOR SEASONAL PATIENTS ONLY

_____LRD_____Cadaver

Transplant facility name and address_____

_____

_____

Contact Person_____Phone_____

SPECIAL INSTRUCTIONS

_____

_____

_____

_____

PATIENT IS NOT ACCEPTED UNTIL OFFICIAL NOTICE IS RECEIVED FROM RECEIVING UNIT.

Signature_____Title_____Date ____/____/____

(Referring unit person who completes form)