{Your logo here}

Dialysis Unit to Hospital Transfer Summary

Patient Information

Name / ID: _____ **DOB:** / /

Chronic Dialysis Unit Name: _____

Primary Renal DX : _____

Nephrologist: _____

Unit Phone: _____ Nephrologist Phone: _____

Hepatitis B

Antigen: _____ Antibody:_____

Date: / /

Allergies: _____

_____

Code Status

☐ Full ☐DNR

Other Instructions: _____

Competent to Sign Consents

☐ Yes ☐ No

Reason for Admission

_____

_____

Hospital Name: _____

Date of Admission: / /

Current Vascular Access

PRIMARY	SECONDARY (if any)
☐ CATH	☐ CATH
☐ AVF	☐ AVF
☐ AVG	☐ AVG
☐ Other	☐ Other

Access Location: _____

Access Surgeon: _____

Needle Size: _____

Average bleeding time: _____

Buttonhole cannulation:

☐ NO ☐ YES, Details:

_____

Vascular Access Infection

(within last 30 days):

☐ NO ☐ YES

Positive Blood cultures:

☐ NO ☐ YES

If Yes- name antibiotic(s) given:

_____

Organism type:_____

Dialysis Prescription

TX per week: _____ Duration: _____

Schedule: _____

Dialysate = Na: _____ K: _____ Ca: _____

Bicarb setting: _____

DFR rate: _____ BFR Rate: _____

Dry Weight: _____

Heparin:

Load: _____

Hourly: _____

Mid Tx bolus: _____

Dialyzer: _____

Treatment tolerance:

☐ Well

☐ Fair

☐ Poor

Details: _____

_____

_____

Anemia Management

ESA's given during the admission:

☐ None

☐ Epogen® ☐Aranesp® ☐Procrit®

Last Dose/Date Received:

_____ / /

IV IRON Therapy*:*

☐ Venofer® ☐ Ferrlecit®

☐ Feraheme® ☐ Infed®

☐ Dexferrum® ☐ Other_____

Last Dose/Date Received:

_____ / /

Any RBC transfusions*:* ☐ NO ☐ YES

date(s)_____

HGB prior to transfusion(s) _____gm/dL

Most recent:

Hgb: _____ Date: / /

Hct: _____ Date: / /

Dietary Order

Na: _____ K: _____ Phos: _____ Fluid restriction: _____

Protein: _____ Calories: _____

Routine Dialysis Medications

_____

_____

_____

Attachments

☐ Last 3 HD flow-sheets ☐ Medication list ☐ Care Plan ☐ Other (list): _____

This form completed by _____

Please print above (Name) (Phone) (Date)