{Your logo here}

Hospital to Dialysis Unit Transfer Summary

Patient Information

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

Primary Renal DX : _____

Hepatitis B

Antigen: _____ Antibody:_____

Date: / /

Allergies: _____

_____

Code Status

☐ Full ☐DNR

Other Instructions: _____

Competent to Sign Consents

☐ Yes ☐ No

Hospital Information

Hospital: _____

Unit: _____

Phone:_____

Admission Date: / /

Inpatient Attending Nephrologist(s):

_____

_____

Discharge Date: / /

Discharging Physician: _____

Outpatient Dialysis Unit Accepting Transfer

Facility: _____

Phone: _____

Contact: _____

Current Vascular Access

☐ Tunneled catheter

☐ AVF

☐ AVG

☐ Other_____

_____

Any changes this admission:

☐ Clotting

☐ Declotting

☐ Revision

☐New Placement – Please describe:

_____

Vascular access infection:

☐ No ☐ Yes

Positive blood cultures:

☐No ☐ Yes – Name of antibiotic(s)given:

_____

Organism Type:_____

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: / /

Miscellaneous

Date of last HD prior to discharge: / /

Changes to EDW: _____

Treated for other infections: (list)_____

_____

Medication changes: _____

_____

_____

_____

Other: _____

Co-morbid Conditions - Did the patient receive treatment during this admission for the following conditions?

☐ Pericarditis ☐ Bacterial Pneumonia ☐ GI Bleeding

Discharge Dialysis Prescription/Orders

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:_____

Discharge Instructions

☐ Telephone report to the Chronic HD unit

☐ Report any changes in access placement or function

☐ Verify that transportation arrangements have been made through Social Service

☐Fax following Medical Records:

☐Last three HD treatment sheets

☐ Medication list

☐ Recent lab work-(Chemistries, CBC, Cultures)

☐ H&P, Nephrology consult, Radiology/Scan reports, Discharge Notes

This form completed by _____

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