



# Patient Intake Form

**Admission Type:** ☐ New Admission ☐ Transfer-in Start date requesting: \_\_\_\_\_

☐ Transient From: \_\_\_\_\_ to \_\_\_\_\_

Hospital/Facility Name \_\_\_\_\_ Patients name \_\_\_\_\_

## Contact information:

Your Name: \_\_\_\_\_ Contact #: \_\_\_\_\_

Fax #: \_\_\_\_\_ Email: \_\_\_\_\_

## Patient information :

Nephrologist: \_\_\_\_\_ Special needs: \_\_\_\_\_

**Diagnosis:** ☐ ESRD ☐ AKI **First Date of Dialysis Ever:** \_\_\_\_\_

Check the following:	Yes	No	Access Type
Currently have a trach?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> CVC
Bedbound?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Fistula/Graft
Weight >450lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other _____
Patient in a wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	

Below is the information necessary prior to admitting the patient to Andrews Kidney Care.

- |   |  |
|---|--|
| <input type="checkbox"/> Demographics                 | <input type="checkbox"/> Treatment records         |
| <input type="checkbox"/> Labs (CMP)                   | <input type="checkbox"/> Access placements records |
| <input type="checkbox"/> History & Physical           | <input type="checkbox"/> Hepatitis (Hep) B Panel   |
| <input type="checkbox"/> Nephrology Consultation note | - Hepatitis B Surface Antibodies                   |
| <input type="checkbox"/> Hepatitis C                  | - Hepatitis B Surface Antigens                     |
| <input type="checkbox"/> PPD or chest X-ray           | - Hepatitis B Core                                 |
| <input type="checkbox"/> Home medication list         |  |

To help with continuity of care, please provide the following after the patient is discharged.

- ☐ Discharge Summary
- ☐ Referrals that require follow-up.