Dialysis Unit to Hospital Patient Communication Form

To Be Completed by the Dialysis Unit

Patient Name: _____ D.O.B.: _____

Dialysis Center Name: _____

Phone: _____ Fax: _____

Dialysis day: ☐ M/W/F ☐ T/Th/Sat

Dialysis Shift: ☐ 1st shift ☐ 2nd shift ☐ 3rd shift

Dialysis Orders included with this transmission? ☐ Yes ☐ No

Hepatitis Status: ☐ Susceptible ☐ Immune Date Drawn: _____

Staff completing this form: _____ Date: _____

To Be Completed by the Hospital

Admission Date: _____ Discharge Date: _____

Any Blood Cultures Drawn? ☐ Yes ☐ No Date Blood Cultures Drawn: _____

Blood Culture Results: ☐ Positive ☐ Negative ☐ N/A

If positive, please fax microbiology report to dialysis unit NHSN entry.

Hemodialysis Access Update

Any abnormal access findings? ☐ Yes ☐ No

Any adverse access events? ☐ Yes ☐ No

Any erythropoiesis-stimulating agents (ESAs) given? ☐ Yes ☐ No

If yes, please indicate the Name, Dose, Route, and Date(s) given.

Medication	Dose	Route	Date(s)

Any Follow-up Appointments that the patient should be reminded to schedule or attend? ☐ Yes ☐ No

Note: _____

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