

# Dialysis Unit to Hospital Transfer Summary

Patient Information		Hospital Information
Name/ID: _____	DOB: _____	Reason for Admission
Dialysis Unit Name: _____		
Unit Phone: _____		
Primary Renal DX: _____		Hospital Name: _____
Nephrologist: _____	Phone: _____	
<b>Hepatitis B</b>	<b>Code Status</b>	Date of admission: _____
Antigen: _____ Antibody: _____	Full DNR	Competent to sign consents:
Date: _____	Other Instructions: _____	Yes No
Allergies: _____		

Current Vascular Access			
Primary:	Secondary (if any):	Access surgeon: _____	Access Infection (last 30 days):
Catheter	Catheter	Needle Size: _____	Yes No
AVF	AVF	Average bleeding time: _____	Positive Blood Cultures: Yes No
AVG	AVG	Buttonhole Cannulation: No	If yes, antibiotic(s) given: _____
Other	Other	Yes, details: _____	Organism type: _____
Access location: _____			

Dialysis Prescription			
TX per week: _____	Duration: _____	Heparin: _____	Treatment tolerance:
Schedule: _____		Load: _____	Well Fair Poor
Dialysate = Na: _____	K: _____ Ca: _____	Hourly: _____	Details: _____
Bicarb setting: _____	DFR rate: _____	Mid Tx bolus: _____	
BFR rate: _____	Dry Weight: _____	Dialyzer: _____	

Anemia Management			
ESA's given during the admission:	IV Iron Therapy:	Any RBC transfusions:	
None	Venofer®	Yes No	Yes, date(s): _____
Epogen®	Ferrlecit®	HGB prior to transfusion(s) _____ gm/dL	
	Feraheme®	Most recent:	
Last dose: _____	Infed®	Hgb: _____	Date: _____
Date received: _____	Dexferrum®	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: \_\_\_\_\_

Completed by: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_