## **In-Center and Home Clinic Communication Form**

Io Be Completed by In-Center	
Patient Name:	D.O.B.:
Patient Phone:	
Dialysis Center Name:	Contact Person:
Clinic Address:	Clinic Phone:
Nephrologist:	
Dialysis day:  M/W/F T/Th/Sat	
Dialysis Shift: □ 1st □ 2nd □ 3rd □ 1	Nocturnal
Current Dialysis Access:      AV-Fistula     Graft     Central Venous Cathe	eter
Interest Area: <ul> <li>Traditional Home Hemodial</li> <li>Short Frequent Home Hemo</li> <li>Peritoneal dialysis</li> <li>All</li> </ul>	
General Notes:	der se

To Be Completed by Home Clinic		
Home Clinic Name:	Contact Person:	
Home Clinic Address:		
Appointment Date/Time:	-	
Modality Transition		
Home Training Appointment Date/Time:		
In-Center: Please provide most recent lab report and updated me	dication list upon care transition.	
Home: Please note if the patient should bring any of the following items:		
🗆 Blanket 🗆 Drink 🗆 Snack 🗆 Care Partner 🗆	Other Items:	
Additional Info:		



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