Nursing Home Dialysis Patient Communication Form

To Be Completed by Nursing Home	To Be Completed by Dialysis Facility
Patient Name: Date:	Pre-Dialysis Treatment
New medication orders (antibiotics, dose adjustments):	Blood Pressure: Temperature:
Vaccinations given since last dialysis treatment: Pneumococcal COVID-19 Influenza RSV Other Has patient been to hospital since last dialysis treatment? Yes No If yes, list hospital, admit/discharge dates, and diagnosis.	Pulse: Weight: Dialysis Treatment Orders Target Weight: Treatment Duration: Medications administrated during dialysis treatment:
Admit Date: Discharge Date: Diagnosis:	Post-Dialysis Treatment
New Infections? Yes No List Diagnosis and Location:	Blood Pressure: Pulse: Weight:
Blood Cultures Drawn? Yes No	Amount of fluid removed: Did patient complete prescribed treatment:
Date Drawn: Isolation Precautions: Yes No	Yes No If no, why? (cramping, low BP, other symptoms)
If yes, list precautions:	Please note any dialysis access problems (excess bleeding, infiltration, etc):
Upcoming Plan of Care (date): Nurse completing this form: Name: Phone:	Nurse completing this form: Name: Phone:
Please fax any hospital, vaccination, and lab results, including blood cultures to the dialysis facility.	Please attach a copy of any current labs that were drawn.



This material was prepared by Qsource, an End-Stage Renal Disease (ESRD) Network under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 25.ESRD.01.006