U.S. RENAL CARE®

ID - 22632

USRC Patient Admissions Checklist

PATIENT INFORMATION

Patient Full Name: ______________________________

Street Address: ______________________________

City: ____________ **State:** ____________ **ZIP Code:** ____________

DOB: ____________ **Gender:** ____________ **Phone:** ____________

SSN: ____________ **First Date of Dialysis Ever:** ____________

REFERRAL SOURCE INFORMATION

Home Clinic: ______________________________

Contact Person: ______________________________

Phone: ____________ **Fax:** ____________

REQUESTED FACILITY INFORMATION

Requested USRC Clinic: ______________________________

Modality:

- ☐ ICHD
- ☐ CAPD
- ☐ AKI
- ☐ CCPD
- ☐ NXSTAGE

Start Date: ____________ **Number of Treatments:** ____________

Requested Chair Time: ____________

Attending Physician: ____________

INSURANCE INFORMATION

Primary: ____________ **ID #:** ____________ **ID #:** ____________

Secondary: ____________ **ID #:** ____________ **ID #:** ____________

LABS *For Office-Use Only*

Date (Treatment Month): ____________			Date (Previous Month): ____________		
CA: ______	HGB: ______	URR: ______	CA: ______	HGB: ______	URR: ______
PHOS: ______	HCT: ______	Kt/V: ______	PHOS: ______	HCT: ______	Kt/V: ______

USRC Required Records Checklist

ALL PATIENTS (REQUIRED)

- ☐ Patient Demographic / Registration Sheet
- ☐ Hep B Antigen (within 30 days) or Hep B Antibody (within 1 year)
- ☐ Last 3 Flow Sheets
- ☐ Medication List
- ☐ History and Physical (within 30 days)

ALL PATIENTS (OPTIONAL)

- ☐ Vaccine Records
- ☐ Progress Notes
- ☐ Consultation (Most Recent)

TRANSFER & TRANSIENT PATIENTS

- ☐ Insurance Cards (Front & Back)
- ☐ HCFA 2728
- ☐ Hemodialysis Orders
- ☐ PPD or Chest X-Ray (within 1 year)
- ☐ Interdisciplinary Assessment and Plan of Care