


Patient Admissions Form

Please complete this form in its entirety and submit this form along with all required documents (listed below) via email or fax.

	TOLL FREE	MAIN FAX	EMAIL
	(800) 550-9664	(615) 234-2416	admissions.inbox@usrenalcare.com

ADMISSION TYPE:	New to Dialysis	Transfer	Visitor (visiting <30 days)	Modality change only
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PATIENT INFORMATION

Patient Name:	DOB:
Phone:	First day of ESRD (if appl.):

REFERRAL SOURCE INFORMATION

Referring Nephrologist:	Same	Referring Clinic/Hospital:	Phone:
Accepting Physician:		Contact Person:	Fax:
			Email:

REQUESTED FACILITY INFORMATION

Requested Clinic/Program Name:	Requested Start Date:
Requested Clinic/Program City, State:	
In-Center HD Treatment Time >4 hours? YES NO	# of treatments (only if visitor for <30 days):
Preferred Treatment Schedule: Day MWF TTS Time AM PM	Is the patient flexible with: Facility Yes No Shift Yes No

MODALITY, DIAGNOSIS, AND ACCESS TYPE – please select the modality, patient diagnosis, and access type

Modality:	IN-CENTER HD	HOME HD	PD	Diagnosis:	ESRD	AKI	Access Type:	CVC	Fistula	Graft	PDC
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PATIENT CLINICAL INFORMATION – responses to these questions are required to confirm admission

<p>Does the patient have a clinically active infection that may pose a risk to others? YES NO</p> <p>If yes, please specify: Resistant organisms e.g., MRSA, VRE, MRSE, Candida HBV Tuberculosis</p>	<p>Are there any medical accommodations that need to be made for the patient? YES NO</p> <p>If yes, please specify: IV medication, non-formulary LifeVest LVAD Tracheostomy (capped) BiPap (open Tracheostomy)</p>	<p>Are there any other special accommodations that need to be made for the patient? YES NO</p> <p>If yes, please specify: Hoyer lift Bariatric chair Dialysis bed or stretcher Pediatric patient</p>
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REQUIRED AND REQUESTED DOCUMENTS AND MEDICAL RECORDS (please see footnote* for additional state-specific requirements)

PATIENTS NEW TO DIALYSIS	TRANSFER PATIENTS <i>(Current ESRD, transfer for at least 30 days)</i>	VISITING PATIENTS <i>(Current ESRD, visiting for <30 days)</i>
<p>Required:</p> <ul style="list-style-type: none"> Demographic sheet, including insurance info History and Physical and/or last 2 Nephrologist notes (within last 30 days) 1 dialysis flowsheet (within 2 weeks of admission) Hepatitis B Labs: HBsAg (within last 30 days) <p>Requested if available:</p> <ul style="list-style-type: none"> Labs (within last 30 days) HBV panel (within last year) PPD, Chest X-Ray, QuantiFERON-TB Gold (QFT) (within last 30 days) COVID Vaccination Record KrU/Residual Urea Clearance (PD Patients only) 	<p>Required:</p> <ul style="list-style-type: none"> Demographic sheet, including insurance info History and Physical (within last 1 year) 1 dialysis flowsheet (within 2 weeks of admission) Hepatitis B Labs: HBsAg (within last 30 days) or anti-HBs ≥10 (within last year) <p>Requested if available:</p> <ul style="list-style-type: none"> Labs (within last 30 days) HBV panel (within last year) External: PPD, Chest X-Ray or QuantiFERON-TB Gold (QFT) (within last year) Internal: TB verify in EMR Plan of Care (current) COVID Vaccination Record 	<p>Required:</p> <ul style="list-style-type: none"> Demographic sheet, including insurance info History and Physical (within last 1 year) 1 dialysis flowsheet (within 2 weeks of admission) Dialysis orders including active meds (current) Hepatitis B Labs: HBsAg (within last 30 days) or anti-HBs ≥10 (within last year) Hgb/Hct (Previous Month), URR, Kt/V (Current Month) External: PPD, Chest X-Ray or QuantiFERON-TB Gold (QFT) (within last year) Internal: TB - verify in EMR Plan of Care (current) 2728 form <p>Requested if available:</p> <ul style="list-style-type: none"> HBV panel (within last year) COVID Vaccination Record

*DE, HI, NJ require complete HBV panel (within last year); TX requires complete HBV panel (within 30 days); HI requires PPD or CXR; AZ, CO, DE, SC require H&P (within last 30 days)