



THE ROGOSIN INSTITUTE
Centers For Medical Research And Health Care

**Transient /Transfer Dialysis Patient
Form #1**

Patient Name: _____ Today's Date: _____

Street & Apt. #: _____ Home Phone: _____

City/State/Zip: _____ Work Phone: _____

Modality: _____ In-Center Hemo: _____ Home Training: _____ Peritoneal: _____

Referring Unit: _____ Contact Person: _____

_____ Phone: _____

REQUESTED INFORMATION

ATTACHED

Patient Demographic/ID Sheet- emergency contact information _____
Copy of insurance cards- front and back _____
HCFA 2728 – Medical Evidence Report _____
MSP Questionnaire _____

Three most recent dialysis treatment sheets _____
Dialysis Orders _____
History & Physical- including medical diagnoses _____
Dietary, Nursing and Psycho-Social Assessments _____
Psychiatric History-to include diagnosis _____
Long-term care plan _____

Medication Record- including allergies _____
Lab report- current and prior month (Hgb & URR) _____
Hepatitis B Antigen within 30 days _____
EKG _____
PPD/Chest X-Ray (within past year) _____
PC Placement X-Ray _____

Patient's height (cm) _____

COMMENTS/SPECIAL INSTRUCTIONS

Please fax back to social worker at appropriate dialysis center:

Manhattan Dialysis Center: 212-746-8439
Queens Dialysis Center: 718-457-3280
Brooklyn Dialysis Center: 718-780-7252