



THE ROGOSIN INSTITUTE
Centers For Medical Research And Health Care

**Transient/Transfer Dialysis Patient
Form #3 – Current Medical Information**

Patient Name: _____ SSN: _____

Primary Nephrologist: _____ Nephrologist Phone: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Allergies: _____

Treatment Length: _____ Times per Week: _____

Dry Weight: _____ Kgs Height: _____ cm Dialyzer: _____

Blood Flow Rate: _____ Dialysate K Bath: _____

Present Access: _____

Date Placed: _____ Placed by Whom: _____

Needle Size: _____ Access Site: _____

Secondary Access (if any): _____

Date Placed: _____ Placed by Whom: _____

Heparin Installation in Permcath Dialysis: Arterial Line: _____ Units: _____

Venous Line: _____ Units: _____

Heparinization: Initial: _____ Hourly: _____ Pump Off: _____ Minutes: _____

Dialysis Medication(s):

Epogen: _____ Venofer: _____

Zemplar: _____ Calcitrol: _____

Comorbid Conditions: _____

Intradialytic Problems/Comments: _____

Special Needs: _____

Information verified by: _____ Date: _____
Name Title