# Rogosin Institute

# Admissions Intake Form

**Date:** ______/______/________

**Patient Name:** ____________________

**Admission Type: (Please check)**
☐ **New Admission** ☐ **Transfer In** ☐ **Readmission (past 30 days)** ☐ **Resume (within 30 days)** ☐ **Transient**

Contact Name: ____________ Contact Phone: ____________ Contact E-mail: ____________

Hospital/Dialysis Unit/Practice: ____________________

Primary Nephrologist (if known): ____________ Nephrologist Phone (if known): ____________

## STEP 1: SCHEDULE A PATIENT

**Please provide your patient's INFORMATION SHEET (insurance & demographics) and the information in this section by PHONE or FAX.**

Requested Facility or Zip Code: ____________

Patient Start Date: ____________

Treatment Duration & Frequency: ____________

Preferred Schedule:

☐ MWF ☐ TTHS ☐ AM ☐ PM

Patient Flexibility: (check all that apply)

☐ Shift ☐ Day ☐ Time ☐ Facility

## STEP 2: FINALIZE PLACEMENT

**TO CONFIRM ADMISSION, please FAX the following:**

- Last 3 HD treatment records (if available)
- Current history & physical (within last year)
- Albumin, creatinine, hemoglobin labs (pre-1st dialysis treatment for new starts)
- PPD or chest X-ray (within 90 days)
- Most recent monthly lab results (within 30 days)
- Most recent Hepatitis Panel
  - Hep B Antigen (HBsAG) (within 30 days)
  - Hep B Surface Antibody (HBsAB) (within 12 months)
  - Hep B Total Core Antibody (HBcAB) (within 12 months)
- Psychosocial Assessment
- Ambulation Status
  - ☐ Ambulatory without assistance
  - ☐ Ambulatory with device (walker, cane, etc.)
  - ☐ Requires stretcher transport

## PATIENT CARE

**Please provide the following information via fax (CHECK BOXES FOR AMBULATION STATUS CHOICES) or phone if applicable:**

**MODALITY:**

☐ In-Center Hemo
☐ Nocturnal
☐ Home Hemo
☐ PD

**DIAGNOSIS:**

☐ ESRD
☐ Acute Renal Failure

First Date Of Dialysis Ever:

______/______/______

**ACCESS TYPE:**

☐ Graft ☐ Fistula ☐ CVC

Date of access placement ____________

Date access first used ____________

Other: ____________

Does the patient:

Have a tracheostomy? ☐ Y ☐ N

Require treatment in bed? ☐ Y ☐ N

Other special needs? ____________

## PRIOR TO FIRST TX

**Admitting clinic may ask for these additional records, as necessary, to safely treat the patient. Please submit via fax upon request.**

- Current medication list
- Allergies
- Consultations (Cardiology, GI, etc.)
- Access/associated operative reports
- Discharge summary sheet
- Advanced directive
- EKG
- HIV test result (if applicable)
- 2728 (if applicable)