CENTRACARE KIDNEY PROGRAM

Alexandria, Big Lake, Brainerd, Cambridge, Litchfield,
Little Falls, Princeton, Staples, St. Cloud, Minnesota

Admissions Nurse: Angie W.
Phone: 320-251-2700 ext: 24552
Fax number: 320-632-0479

Please Fill Out This Form and Return With Patient Records.
This form must be completely filled out for patient acceptance

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PATIENT INFORMATION (PLEASE PRINT)

Patient's Name (first, Middle Initial, Last)
____

Dates Requested:____

Address ________________________ City ________________ State ____________

Zip Code ____________ County ____

Home Phone Number ______________________Cell Number _________________

Visiting Address______________________ City ____________________________

Visiting Phone Number ______________ Visiting Phone _____________________

Visiting Emergency Contact Person _______________ Phone _________________

Sex ____________ Marital Status: M D S Date of birth _________________________

Employer __________________________ Occupation __________________________

Work Phone ____________________ Employment Status: Full-time Part-Time Retired

Social Security Number _______________ Primary Language ___________________

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR BILL)

Name ______________________________ Address ______________________________

City ________________________________ State ________________ Zip Code _______

County _____________________________ Home Phone Number ___________________

Social Security Number _____________________ Relationship to Patient ____________

CONTACT PERSON IN CASE OF EMERGENCY

Name of Contact Person ___________________________ Home Phone ______________

Cell Phone ______________________ Work Phone ______________________________

Relationship to patient ___________________________

INSURANCE INFORMATION

Check appropriate space below.

☐ Medicare I.D. Number ________________Coverage (circle one) A & B A only B only
Eligible Dates from ______________ to _________ Spouses Name ______________
Spouses Date of Birth ____________________

☐ Other Insurance: Name of Insurance Company _________________________________
Policy Holder's Social Security Number ____________________________________
Policy Number ____________________ Group Number _______________________

PATIENT TREATMENT INFORMATION

Patient Name____

Primary Diagnosis ____

Dry Weight _____________kg. Height ______________ Duration__________________

Times per week______ Dialyzer________________ Reuse _______________________

BFR ____________ DFR ____________ Access:(type & location_________________

K+ ___________ Ca ++ ____________ Na + __________________________________

Heparin: Load ______________ Maintenance ___________________ Tie ___________

Bicarbonate Concentration ______________ Dialysate Temperature ________________

Allergies ____

Dialysis Medication/ Dosage ____

____

Intradialytic Problems/Comments: ____

____

Code Status _______________________

Intradialytic Blood Pressures __________ Intradialytic Venous Pressures ____________

Intradialytic Diet/Fluid Restrictions ____

Hepatitis B antigen (within 1 month) results __________________ Date _____________

Hepatitis B Antibody (within 6 months) results ________________ Date _____________

PPD (within 1 year or chest x-ray) results ________________ Date _________________

This Form was Completed by (*Name and Title please print*)