PUGET SOUND kidney centers

New Patient Admission Intake Form:

Please note: All of the following items must be received before a dialysis appointment will be scheduled.

Patient Name:_____ DOB: _____ Height(CM):_____

Nephrologist:_____ Primary Cause dx of ESRD:_____ AKI dx:_____

Date of First Dialysis **Ever**: _____ Location of First Dialysis: _____ Expected Start Date: _____

☐ New Patient ☐ Acute (AKI) ☐ Transfer In ☐ Return frm Transplant ☐ Return frm Regain ☐ Return frm Hospital

Preferred Unit: ☐ **Home** ☐ **Smokey Point** ☐ **Whidbey** ☐ **Anacortes** ☐ **Everett** ☐ **Monroe** ☐ **MT LK Terrace**

☐ **Lakewood** ☐ **Bremerton** ☐ **Poulsbo** ☐ **Port Orchard** ☐ **Port Townsend**

☐ Medical Records are available via EPIC EMR ☐ Providence ☐ Swedish ☐ Other

OR attach hard copies:

☐ Patients without a fistula or graft must have an appointment with the vascular surgeon prior to admission to the dialysis unit.

Vascular Surgeon:_____ Appointment date: _____

☐ Surgical Access Placement Report (if available)

☐ Admitting History and Physical (within 6 months preferred)

☐ Nephrology Consult (if available)

☐ PPD or Chest X-ray noting no evidence of TB within 12 months of admission to dialysis unit

☐ Hep B Surface Antigen (if antibody < 10, result must be within 30 days of admission; if equal or > 10, result must be within 12 months)

☐ Hep B Surface Antibody (within previous 12 months) and ☐ Hep B Core Antibody (any draw date)

☐ Current Labs within 30 days of first treatment date **GFR**: _____

☐ Initial Orders completed and signed by Nephrologist **Diabetic:** ☐ Yes ☐ No

☐ Face sheet including insurance information and demographics

☐ Copy of insurance cards **Full Social Security#:** _____

For Transfer in Patients only:

☐ Last three treatment records ☐ Copy of 2728

☐ Assessment and Care Plan (within 12 months) ☐ Immunization/Vaccine History (if available)

Please check if any of the following apply:

☐ Receives premium assistance from WA Kidney Disease Program or American Kidney Fund

☐ Inability to follow directions and cooperate with staff instructions.

☐ Skin breakdown that requires frequent position changes.

☐ Parenteral or Enteral Nutritional Support.

☐ Chronic incontinence of stool.

☐ Hoyer sling needed. Has had amputation: ☐ Yes ☐ No

☐ Other medical conditions which require non-standard ambulatory care delivery: _____

PLEASE FAX or EMAIL ALL OF THE ABOVE RECORDS TO:
PUGET SOUND KIDNEY CENTERS – ATTENTION ADMISSIONS COORDINATOR
PHONE: 425-259-2003 FAX: 425-403-4008 EMAIL: admissions@pskc.net