

Visitor Hemodialysis Patient Form
(Please type or print legibly)

Date: _____
Name: _____ Gender: M F
Social Security #: _____ Date of Birth: _____
Center of Origin: _____
Address: _____

Phone: _____ Dates to be Dialyzed at UIHC: _____
ESRD Etiology: _____
1st Chronic Dialysis Date: _____
Other Medical Problems: _____

Access: _____ Dialyzer: _____
Dialysate: K: _____ Ca: _____ HCO₃: _____ Blood Flow: _____
Duration: _____ Target Weight: _____ Heparin Dose: Bolus: _____ Hourly: _____
Lab Date: _____ Hb: _____ Hct: _____ BUN: _____ Cr: _____ Na: _____
K: _____ Cl: _____ CO₂: _____ Ca: _____ PO₄: _____
HbSag: _____ HbSab: _____ Hep. C: _____ URR: _____ Height: _____

Medications (please list all medicines [home and during dialysis] including doses):

PRINT NAME AND SIGNATURE OF PERSON COMPLETING THIS FORM

Please use a separate piece of paper to include all other pertinent information.

We must have the following: H & P, Complete Lab Screening Results including Hep B and C, CXR, EKG (drawn within 6 months of the transient dialysis treatment with UIHC); H&H and URR (result must be within the last 30 days before transient dialysis treatment with UIHC); Medication List, completed 2728 form, copies of insurance cards (front/back) and 3 most recent flowsheets (just before transient dialysis treatment), 6 month multidisciplinary care plan with dietary and social service assessments. Incomplete information can result in delay or not being accepted for transient dialysis treatments.