

**MORGAN CITY DIALYSIS CENTER ACCEPTANCE FORM:**

**How did you hear about us?** \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Soc Sec #: \_\_\_\_\_

Phone #: \_\_\_\_\_ 2nd Contact #: \_\_\_\_\_

Local Contact #(s): \_\_\_\_\_

Current Address: \_\_\_\_\_

Future/New Address: \_\_\_\_\_

**Marital Status:**

Married: \_\_\_\_\_ Single: \_\_\_\_\_ Divorced: \_\_\_\_\_ Separated: \_\_\_\_\_

Spouse/Partner Name: \_\_\_\_\_

**Employment Status:**

Patient: Yes \_\_\_\_\_ or No \_\_\_\_\_ Employer: \_\_\_\_\_

How long have you worked? \_\_\_\_\_

Address of Employer: \_\_\_\_\_

Spouse: Yes \_\_\_\_\_ or No \_\_\_\_\_ Employer: \_\_\_\_\_

Address of Employer: \_\_\_\_\_

Retired: Patient: Yes \_\_\_\_\_ or No \_\_\_\_\_ Date: \_\_\_\_\_

Spouse: Yes \_\_\_\_\_ or No \_\_\_\_\_ Date: \_\_\_\_\_

Company retired from and date: \_\_\_\_\_

Company Address: \_\_\_\_\_

**Financial Status:**

Patient Income: Salary\$ \_\_\_\_\_ Soc Sec \$ \_\_\_\_\_ SSI\$ \_\_\_\_\_ VA\$ \_\_\_\_\_

Spouse Income: Salary\$ \_\_\_\_\_ Soc Sec \$ \_\_\_\_\_ SSI\$ \_\_\_\_\_ VA\$ \_\_\_\_\_

Other Household Income:

Rental Income/Interest Dividends/CD's/Etc. \_\_\_\_\_

Do you own property other than your home/vehicle: \_\_\_\_\_

Do you have Life Insurance/Bural Insurance: \_\_\_\_\_ Face Value: \_\_\_\_\_

**Medical Insurance Coverage:**

Medicare #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Medicaid #: \_\_\_\_\_ Issue Date: \_\_\_\_\_

Private Insurance (Primary): ID#: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Supplemental Insurance: ID#: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Medicare Advantage/PPO Plan: \_\_\_\_\_

(Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_)

**\* Please provide a copy of front and back of ALL insurance cards\***

**MORGAN CITY DIALYSIS CENTER ACCEPTANCE FORM CONTINUED:** Pg 2 of 3

Patient Name: \_\_\_\_\_

Reason for Disability: \_\_\_\_\_

Physical Condition: Weight \_\_\_\_\_ Height \_\_\_\_\_ Amputee: Bi-Lateral or Lateral

Patient Mobile on his/her own: Yes \_\_\_\_\_ or No \_\_\_\_\_

Patient Uses a Wheelchair: Yes \_\_\_\_\_ or No \_\_\_\_\_ Size: \_\_\_\_\_

Patient Uses a Stretcher: Yes \_\_\_\_\_ or No \_\_\_\_\_

Reuse of dialyzers: All of our units do centralized reuse of dialyzers. All new accepted new patients must take part in the reuse program. If you refuse to take part in the reuse program we will assist you in finding another facility for your dialysis needs.

Yes \_\_\_\_\_ or No \_\_\_\_\_

Patient's Signature

Referred By: \_\_\_\_\_

Patient Nephrologists Name: \_\_\_\_\_

Place of Current Dialysis: \_\_\_\_\_

Phone # of current dialysis: \_\_\_\_\_

Social Workers Name: \_\_\_\_\_

Date of First Dialysis \_\_\_\_\_ Place of First Dialysis \_\_\_\_\_

Medical Diagnosis: \_\_\_\_\_

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**For Office Use Only:**

Patient Accepted \_\_\_\_\_ /Not Accepted \_\_\_\_\_ By: \_\_\_\_\_

Reason for not accepting patient \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other Information/Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Acceptance Completed By \_\_\_\_\_ Date \_\_\_\_\_

**REQUIRED DOCUMENTS FOR PATIENT ACCEPTANCE:**

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Patient Name: \_\_\_\_\_

Please Check One of The Following:

New Patient to Dialysis \_\_\_\_\_ Transfer Patient \_\_\_\_\_ Transient Patient \_\_\_\_\_

Please include ALL of the following:

**New Patient to Dialysis:NEEDED PRIOR TO STARTING IN FACILITY**

- \_\_\_\_\_ Patient Acceptance Form (filled out completely)
- \_\_\_\_\_ Copy of ALL insurance cards and ID's front and back
- \_\_\_\_\_ Copy of the last 3 flow sheets
- \_\_\_\_\_ If patient is a diabetic HgbA1C
- \_\_\_\_\_ PTH intact
- \_\_\_\_\_ Basic Chemistry, CBC (with in 30 days of 1st treatment)
- \_\_\_\_\_ Iron panel plus Ferritin
- \_\_\_\_\_ Albumin, if available
- \_\_\_\_\_ Lipid Panel with in 1 year of 1st treatment, if available
- \_\_\_\_\_ Hep Status (HBsAg,HBs Ab, HC Ab, HIV, HBcore antibody total) within 30 days
- \_\_\_\_\_ CXR
- \_\_\_\_\_ EKG
- \_\_\_\_\_ H/P& access history
- \_\_\_\_\_ TB Skin test
- \_\_\_\_\_ Influenza and Pneumonia vaccine
- \_\_\_\_\_ Our facility is a reuse facility and everyone accepted must agree to reuse
- \_\_\_\_\_ Patient's Initials agreeing to reuse

**Transfer patient:New patient information plus the following**

- \_\_\_\_\_ 2728
- \_\_\_\_\_ Long Term Care Plan
- \_\_\_\_\_ Transplant Referral Information
- \_\_\_\_\_ Most Recent Labs (with in 30 days)
- \_\_\_\_\_ Hep B Vaccination Documentation

**Transient patient: New patient information plus the following**

- \_\_\_\_\_ 2728