

RACELAND 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***

RACELAND 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: _____

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