ST. JAMES 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***

ST. JAMES DIALYSIS CENTER ACCEPTANCE FORM CONTINUED:

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 centrallized 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:

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