# DaVita Admissions Intake Form

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|---|---|---|---|
| **Your Name** | | **Date:** | |
| **Contact Number** | | **Hospital/ Practice:** | |

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|---|---|
| **Patient Name** | **Attending Nephrologist** *(Outpatient Dialysis)* |

**Notes**

## STEP 1 :: For Placement

To **secure a placement,** please **COMPLETE** this form and **FAX it** along with the **Face Sheet** *(insurance and demographics).*

| | | |
|---|---|---|
| **First Day of Dialysis Ever** | ____ ____/ ____ ____/ ____ ____ | |
| **Diagnosis** | ☐ ESRD<br>☐ Acute Renal Failure | |
| **Prescription** | **Modality**<br>☐ In-Center Hemo<br>☐ Nocturnal<br>☐ Home Hemo ☐ PD | **Tx Duration**<br>_____ hrs<br>_____ mins |
| | **Treatment Frequency**<br>☐ 2x ☐ 3x ☐ 4x ☐ Other _____ | |
| **Access type** | ☐ Catheter ☐ Fistula ☐ Graft<br>☐ PD Catheter<br>☐ Other _____ | |
| **Hep B Antigen (HBsAg) Status** | ☐ Negative ☐ Unknown<br>☐ Positive ☐ Testing *(in process)* | |

| | |
|---|---|
| **Anticipated DaVita Start Date** | ____ ____/ ____ ____/ ____ ____ |
| **Preferred Schedule** | ☐ MWF<br>☐ TTS _____am/pm<br>☐ Patient is flexible |
| **Requested Facility(s) or Zip Code** | ☐ Patient is flexible |

### Special Needs

*Available at selected DaVita facilities*

| | |
|---|---|
| **Does patient have tracheostomy?** | ☐ Yes ☐ No |
| **Does patient require a treatment in a bed?** | ☐ Yes ☐ No |

## STEP 2 :: Prior to Admission

Please **FAX** the following information **PRIOR TO** admission.

- ☐ **Hep B Antigen*** *(HBsAg) (drawn within 30 days)*
- ☐ **Hep B Surface Antibody*** *(HBsAb) (drawn within 12 months)*
- ☐ **Hep B Total Core Antibody*** *(HBcAb) (drawn within 12 months)*

*Per the CMS Conditions for Coverage, above Hep B results are required prior to admission.

- ☐ **PPD or Chest X-Ray** *(within 90 days)*
- ☐ **History and Physical**
- ☐ **Consultations**
- ☐ **Access info /Associated Operative Reports**
- ☐ **Allergies**
- ☐ **Labs** *(current and prior to dialysis)*
- ☐ **EKG** *(if available, OR if patient has known heart condition)*

*If available…*

- ☐ **Physician Dialysis Order**
- ☐ **Medication List**
- ☐ **Discharge Summary**
- ☐ **Dialysis Flow Sheets** *(up to three )*
- ☐ **RN Notes**

**PHONE: 1-877-655-5022**
**FAX: 1-888-317-8319**