### Dialysis Admissions Intake Form

**P: 1-888-ROGOSIN (1-888-764-6746)  F: 646-317-0516**

**Patient Name:** ___________________________  **Date:** ________/______/______

**Admission Type:** (Please check)

- [ ] New Admission  - [ ] Transfer In  - [ ] Readmission (past 30 days)  - [ ] Resume (within 30 days)  - [ ] Transient

**Contact Name:** ___________________________  **Contact Phone:** ________________  **Contact E-mail:** ___________________________

**Hospital/Dialysis Unit/Practice:** ___________________________

**Primary Nephrologist (if known):** ___________________________  **Nephrologist Phone (if known):** ___________________________

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### STEP 1: SCHEDULE A PATIENT

Please COMPLETE this FORM and FAX it along with patient’s FACE SHEET (insurance & demographics.)

**Requested Facility or Zip Code:** ___________________________

**Anticipated Start Date:** ___________________________

**Preferred Schedule:**  
- [ ] MWF  
- [ ] TTHS  
- [ ] AM  
- [ ] PM  

**Patient is Flexible:**  [ ]

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### STEP 2: FINALIZE PLACEMENT

To CONFIRM ADMISSION, please FAX the following:

- Last 3 HD treatment records (if available)
- Current history & physical (within last year)
- PPD, Chest X-Ray (within 90 days) or QUANTIFERON
- Albumin ___, Creatinine ___, Hemoglobin ___
- Most recent monthly lab results (within 30 days)
- Most recent Hepatitis Panel  
  - Hep B Antigen (HBsAG) (within 30 days)  
  - Hep B Surface Antibody (HBsAB) (within 12 months)  
  - Hep B Total Core Antibody (HBCAB) (within 12 months)
- Psychosocial Assessment
- COVID 19 Result within 72 hours prior to admission

**IF AVAILABLE:**

- Discharge summary sheet
- Consultations
- Access/associated Operative Reports
- EKG
- 2728 (if applicable)
- COVID 19 Vaccination Record

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### PATIENT CARE

**First Date of Dialysis Ever:** ________/______/______  
**Treatment Duration:** ___ hrs ___ mins  **Frequency:** ______

**MODALITY:**  
- [ ] In-Center Hemo  
- [ ] Home Hemo  
- [ ] PD

**DIAGNOSIS:**  
- [ ] ESRD
- [ ] Acute Renal Failure

**ACCESS TYPE:**  
- [ ] Graft  
- [ ] Fistula  
- [ ] CVC

**Date of access placement:** ________/______/______  
**Date access first used:** ________/______/______

**Other:** ___________________________

**SPECIAL NEEDS:**

- Does the patient have a tracheostomy?  
  - [ ] Y  
  - [ ] N

- Require treatment in bed?  
  - [ ] Y  
  - [ ] N

- Other special needs?  ___________________________

**AMBULATION STATUS:**

- [ ] Ambulatory without assistance
- [ ] Ambulatory with device (walker, cane, etc.)
- [ ] Requires stretcher transport

**MODE OF TRANSPORTATION:** ___________________________

**Notes:**

*Please use this page as your fax cover sheet.*