U.S. RENAL CARE®

ID - 22632

USRC Patient Admissions Checklist

PATIENT INFORMATION

Patient Full Name: _____

Street Address: _____

City: _____ **State:** _____ **ZIP Code:** _____

DOB: _____ **Gender:** _____ **Phone:** _____

SSN: _____ **First Date of Dialysis Ever:** _____

REFERRAL SOURCE INFORMATION

Home Clinic: _____

Contact Person: _____

Phone: _____ **Fax:** _____

REQUESTED FACILITY INFORMATION

Requested USRC Clinic: _____

Modality:

- ☐ ICHD
- ☐ CCPD
- ☐ CAPD
- ☐ NXSTAGE
- ☐ AKI

Start Date: _____ **Number of Treatments:** _____

Requested Chair Time: _____

Attending Physician: _____

INSURANCE INFORMATION

Primary: _____ **ID #:** _____ **ID #:** _____

Secondary: _____ **ID #:** _____ **ID #:** _____

LABS *For Office-Use Only*

Date (Treatment Month): _____

CA: _____ **HGB:** _____ **URR:** _____

PHOS: _____ **HCT:** _____ **Kt/V:** _____

Date (Previous Month): _____

CA: _____ **HGB:** _____ **URR:** _____

PHOS: _____ **HCT:** _____ **Kt/V:** _____

U.S. RENAL CARE®

USRC Required Records Checklist

ALL PATIENTS

- ☐ Vaccine Records
- ☐ Progress Notes
- ☐ Consultation (Most Recent)

TRANSFER & TRANSIENT PATIENTS

- ☐ Insurance Cards (Front & Back)
- ☐ HCFA 2728
- ☐ Hemodialysis Orders
- ☐ PPD or Chest X-Ray (within 1 year)
- ☐ Interdisciplinary Assessment and Plan of Care

NEW DIALYSIS PATIENT

- ☐ Patient Demographic / Registration Sheet
- ☐ Hep B Antigen (within 30 days) or Hep B Antibody (within 1 year)
- ☐ Last 3 Flow Sheets
- ☐ Medication List
- ☐ History and Physical (within 30 days)