

# Health PEI

## Patient Request for Visiting Dialysis

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PATIENT INFORMATION LABEL

NAME:

\_\_\_\_\_

ADDRESS:

\_\_\_\_\_

MRN:

\_\_\_\_\_

▶ Sending Unit: Please attach a fax cover sheet in front of this letter prior to sending (for patient privacy)

### REQUEST

Patient Name: TROY CHAPMAN

Has requested dialysis treatment at the following dialysis unit: **Queen Elizabeth Hospital (Charlottetown)**

On the following dates and times: July 13, 15, 16, 18, 20, 22, 23, 25

#### Please fax the attached 3 forms:

- *Checklist for Visiting Dialysis Patient*
- *Visiting Dialysis Patient History & Physical Update*
- *Visiting Dialysis Patient Information*
- *Non-Resident Consent form*

**within 2 weeks** of receiving this request. We cannot confirm dialysis treatment until the information has been reviewed by our Nephrologist. The sooner the information is received, the sooner the patient can make his/her travel arrangements. At a minimum we like to receive the information **at least 4 weeks** before the first run.

Please fax the attached *Visiting Dialysis Patient Information Update* form and 3 recent run sheets/log **immediately prior to the patient's visit**. Please feel free to contact me if you have any questions.

Sincerely,

Bernadine Lemieux  
Provincial Renal Program Admin Support  
[bmlieux@ihis.org](mailto:bmlieux@ihis.org)  
902-303-7069

Adapted from B.C. Renal 2023



# Health PEI

## Checklist for Visiting Dialysis Patient

### PATIENT INFORMATION LABEL

NAME:

ADDRESS:

MRN:

▶ Please fax (1) this *Form* with the requested documentation, (2) the *Visiting Dialysis Patient Information Form* and (3) the *Visiting Dialysis Patient History & Physical Update form* **within 2 weeks** of receiving this request. We cannot confirm dialysis treatment until the information has been reviewed by our Nephrologist.

Requirement	Attached
Visiting Dialysis Patient Information form (see template attached 3 pages)	<input type="checkbox"/>
<b>History &amp; Physical clinic letter within the last 12 months must be attached and Visiting Dialysis Patient H&amp;P Update form completed.</b>	<input type="checkbox"/>
Visiting Dialysis Patient History & Physical Update form completed by the Nephrologist (see template attached)	<input type="checkbox"/>
Recent laboratory tests:	<input type="checkbox"/>
1. Most recent monthly bloodwork	<input type="checkbox"/>
2. Hepatitis B blood test (HBsAG) completed within the past 3 months	<input type="checkbox"/>
3. HCV within the last 6 weeks	<input type="checkbox"/>
4. HIV within the last year	<input type="checkbox"/>
5. Negative covid swab, only if symptomatic prior to travel (rapid test)	<input type="checkbox"/>
6. Covid vaccine status	<input type="checkbox"/>
1. <b>MRSA:</b> Patient must be negative for Methicillin-Resistant Staphylococcus Aureus (MRSA) Swabs should be collected <b>within the last 4 weeks</b> . Nasal Swab – 1 swab from nares, 1 Peri Anal Swab	<input type="checkbox"/>
2. <b>VRE:</b> Patient must be negative for Vancomycin – Resistant Enetrococci (VRE) Swabs should be collected <b>within the last 4 weeks</b> - Rectal Swab / Stool Sample	<input type="checkbox"/>
3. <b>CRE:</b> Patient must be negative for Carbapenem-resistant Enterobacteriaceae (CRE) Swabs should be collected <b>within the last 4 weeks</b> - Rectal Swab	<input type="checkbox"/>
Current Medications – sent list of all medications and dosages. <b>MEDICATION LIST HAS BEEN CHECKED AND IS CURRENT.</b>	<input type="checkbox"/>
ECG - last available result, mark N/A if not available	<input type="checkbox"/>
3 recent runs sheets/log	<input type="checkbox"/>
Advanced Care Plan – scope of treatment – resuscitation directions	<input type="checkbox"/>
History of violent/aggressive behavior (in PEI, “orange dot alert”)  <input type="checkbox"/> NO <input type="checkbox"/> YES      If yes, attach: 1. <i>Behavior/Risk Assessment Tool &amp;</i> 2. <i>Behavioral Care Plan / Safety Agreement</i>	<input type="checkbox"/>

### IMMEDIATELY PRIOR TO THE PATIENT’S VISIT:

Please fax a completed Visiting Dialysis Patient Update form (attached) and 3 recent HD run sheets/log. Thank you for your cooperation and for supporting the safety and quality of care for this patient.

Adapted from B.C. Renal 2023



# Health PEI

## Visiting Dialysis Patient Information

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### PATIENT INFORMATION LABEL

NAME:

\_\_\_\_\_

ADDRESS:

\_\_\_\_\_

MRN:

\_\_\_\_\_

▶ Please fax (1) this *Form* with the requested documentation, (2) the *Visiting Dialysis Patient Information Form* and (3) the *Visiting Dialysis Patient History & Physical Update form* **within 2 weeks** of receiving this request. We cannot confirm dialysis treatment until the information has been reviewed by our Nephrologist.

### A) DEMOGRAPHIC INFORMATION

Patient Name:		Gender:
Birth date (DD/MM/YYYY):		
Home Address:		
City:	Province/State:	
Country:	Postal/Zip code	
Telephone (home):	Cell:	
Emergency Contact Name:		
Address:		
Telephone (home)	Cell:	
Provincial Health # (if from within Canada)	Expiry Date:	

### B) HOME DIALYSIS UNIT INFORMATION

Referring hospital (Unit):	
Telephone (include country & area code):	Fax (include country & area code):
Referring Nephrologist:	
Telephone (include country & area code):	Fax (include country & area code):

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C) PATIENT VISIT INFORMATION	
Reason for visit: <input type="checkbox"/> Vacation <input type="checkbox"/> Medical Referral <input type="checkbox"/> Business	
Address while staying at destination:	
Telephone:	
Local contact person name:	Telephone:
Person arranging care: <input type="checkbox"/> Self <input type="checkbox"/> Other	
If Other, Name:	Relationship:
Telephone (include area code)	Fax (include area code):
D) MEDICAL INFORMATION	
Allergies:	
Renal Diagnosis:	
Diabetes Mellitus: <input type="checkbox"/> Yes <input type="checkbox"/> No	Insulin dependent: <input type="checkbox"/> Yes <input type="checkbox"/> No
Other medical conditions:	
Year of HD start:	
E) CARE INFORMATION	
Dialysis days:	
<input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat	
Language(s) spoken:	
Mobility:	
<input type="checkbox"/> Independent	
<input type="checkbox"/> One person assist to transfer or reposition	
<input type="checkbox"/> Two or more persons or mechanical lift to transfer or reposition	
<input type="checkbox"/> Uses mobility aide(s), specify type(s): _____	
Fall risk (specify):	
Blood work required (type & frequency):	
Code Status: <input type="checkbox"/> Refer to resuscitation directions (attached)	
Is blood glucose monitoring required during the HD run? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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F) DIALYSIS PRESCRIPTION							
Target Weight:							
Duration (hours/run)							
Frequency (3/wk)							
Maximum UF target							
Dialyzer	<b>Fresenius</b>	<input type="checkbox"/> Fx600	<input type="checkbox"/> Fx80	<input type="checkbox"/> Fx1000			
	<b>Other:</b> Type:	Membrane:					
Dialysate	K+						
	Ca						
	Na						
	HC03						
	Dialysate Flow (Qd)						
	Dialysate Temp						
Medications as listed on the run sheet (e.g., Iron, ESAs)	Pre-dialysis						
	Intra-dialysis						
	Post-dialysis						
Heparin Anticoagulant	Loading						
	Running (units/h)						
	Stop Time						
	Heparin-free (or heparin substitute)						
Current Vascular access	Type/site & side						
	Needle gauge						
	<b>If CVC:</b>						
	Locking Agent						
	Type of dressing						
	Type of cleaning solution						
	<b>If fistula/graft:</b>						
	Topical or local anesthetic						
	Arterial lumen						
	Venous lumen						
<b>F) Special Considerations</b> (e.g. access cannulation information, preparation of dialyzer, patient to bring own dialyzer, patient to bring own needles, etc) <hr/> <hr/> <hr/>							

Adapted from B.C. Renal 2023



# Health PEI

## Visiting Dialysis Patient History & Physical Update

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PATIENT INFORMATION LABEL

NAME:

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ADDRESS:

\_\_\_\_\_

MRN:

\_\_\_\_\_

▶ Please fax (1) this *Form* with the requested documentation, (2) the *Visiting Dialysis Patient Information Form* and (3) the *Visiting Dialysis Patient History & Physical Update form* **within 2 weeks** of receiving this request. Dialysis reservations cannot be confirmed until the information has been reviewed by our Nephrologist.

### Medical Condition:

No changes in medical condition since the most recent history and physical was completed (attach documentation of most recent history and physical)

**OR**

Changes in medical condition since the most recent history and physical was completed (document changes in space below or attach dictated note, if preferred)

### Fitness to travel:

Patient is fit to travel. Psychosocial history and behavioral care management issues (and specifically violent or aggressive acts) have been considered.

\_\_\_\_\_  
Print name (Nephrologist)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (dd/mm/yy)

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