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Ontario Renal Network

Visit Request Form for Patient on Dialysis

Completed by referring dialysis program

Patient Name: _____

Has Requested Dialysis at Following Dialysis Unit: _____

On The Following Dates (MM/DD/YY): _____ - _____

Referring Regional Renal Program (RRP): _____

Current Modality: ☐ HHD ☐ Nocturnal ☐ ICHD ☐ PD

Current Chronic Dialysis Schedule ☐ MWF ☐ TTS ☐ Other: _____

Preferred Dialysis Shift during Travel ☐ Morning ☐ Afternoon ☐ Other: _____

Total number of treatments required during travel: _____

Dialysis reservations cannot be confirmed until this package is completed with all required information, and it has been reviewed by the requested Regional Renal Program and their Nephrologists.

☐ Fitness to travel as certified by Nephrologist Nephrologist Name: _____
☐ Fitness to travel as certified by Nurse Practitioner Nurse Practitioner Name: _____
☐ Fitness to travel as certified by Physician Assistant Physician Assistant Name: _____

Contact Information of Requested Program

Program Name: _____

Phone Number: _____

Fax: _____

Email Address: _____

Has patient dialyzed at this requested RRP before: ☐ Yes ☐ No Program is an EPIC Site: ☐ Yes ☐ No

Referring Unit

RRP Name: _____

Phone Number: _____ RRP Address: _____

Fax Number: _____ Referring Nephrologist Name: _____

Email Address: _____ Nephrologist Signature: _____

Primary Clinical Unit Contact Name: _____ Nephrologist Phone Number: _____

Clinical Unit Email Address: _____ Nephrologist Email Address: _____

Clinical Unit Phone Number: _____

Please submit this form to the attention of: _____

Note: RRP specific contact to be added in

Consent

Patient or Substitute Decision Maker Signature: _____or ☐ verbal agreement
Date of Signature or agreement (MM/DD/YY):_____

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Document Checklist for Visit Request Form

Please ensure all listed documents are included in the Visit Request Form Package prior to submitting

Required Documents	
Recent Medical History with Nephrologists Signature or eSignature, including an attached summary of primary renal diagnosis and renal comorbidities	☐ Attached
Recent Blood Work Results (within the last 4-8 weeks)	☐ Attached
Infection Screening Results (within _____) *Note: Requested RRP to specify date requirements.* ▪ MRSA ▪ VRE ▪ CPE ▪ Hepatitis B Immunization Status ▪ Hepatitis C	☐ MRSA Attached ☐ MRSA Negative ☐ MRSA Positive ☐ VRE Attached ☐ VRE Negative ☐ VRE Positive ☐ CPE Attached ☐ Immunization completed and attached to this form ☐ Hepatitis B Antigen Negative ☐ Hepatitis B Antigen Positive ☐ Hepatitis B Antibody Negative ☐ Hepatitis B Antibody Positive Antibody Level: _____ mg/dL
Current Medication List	☐ Attached
Signed Consent	☐ Attached
Allergies	☐ NKDA ☐ Attached
Most Recent 3 Dialysis Treatments	☐ Attached
Goals of Care (with most recent associated note)	☐ Attached

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Dialysis Patient Demographic Information & Referring Dialysis Unit Information

Demographic

Full Name: _____	Preferred Name: _____
Sex Assigned at Birth: _____	Gender: _____
Date of Birth (MM/DD/YY):	Health Card Number: _____ Health Card Number Expiry Date (MM/DD/YY):
Canadian Citizen ☐ Yes ☐ No Citizenship (if not Canadian): _____ ☐ Patient has Insurance Coverage Insurance company: _____ Additional insurance information:	Out of Province: ☐ Yes ☐ No Province (if Out of Province): _____
Home Address: _____ Mobile Phone Number: _____ Home Phone Number: _____ Work Phone Number: _____	Preferred Language: _____ Cultural Considerations:
Emergency Contact Name: _____ Relationship: _____ Phone Number: _____ Alternative Contact Name: _____ Relationship: _____ Phone Number: _____	Substitute Decision Maker: _____ Relationship: _____ Phone Number: _____
Code Status & Goals of Care:	☐ Full Code ☐ DNR ☐ Other: _____ Code Status:

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Dialysis Treatment Order, Vascular Access, Medical History, & Patient-Specific Needs Information

Dialysis Treatment Orders

Copies of Last 3 Dialysis Treatments	☐ Attached
Dialysis Duration (hours): _____ Dry Weight (Kg): _____	Dialysate Composition: • Sodium (Na): _____ mmol/L • Potassium (K+): _____ mmol/L • Calcium (Ca): _____ mmol/L • Bicarbonate (HCO3): _____ mmol/L • Magnesium (MG):_____mmol/L • Phosphate (PO4)_____mL of fleet • Other _____
Sodium Profile (if applicable)	
Dialyzer Type: *Note: RRP to share available dialyzers with returning letter*	
Dialysate Flow Rate (mL/min):	
Dialysate Temperature:	
Blood Flow Rate (mL/min):	
Blood Pressure Range (Pre- and Post-Dialysis):	
Anticoagulation (Type and Dosage):	Type Dosage:

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UF Profile or Settings:		
Patient Specific Special Instructions: (e.g., Access cannulation information, preparation of dialyzer, patient to bring own dialyzer, patient to bring own needles, what happens if patients blood pressure drops during dialysis treatment, topical anesthesia)		
Anemia Management	Iron medication: _____ Dosage: _____ Date of last dosage (MM/DD/YY): _____ Route of Administration: _____ Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____	ESA medication: _____ Dosage: _____ Date of last dosage (MM/DD/YY): _____ Route of Administration: _____ Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

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Vascular Access

Primary Access	☐ AV Fistula ☐ AV Graft ☐ Central Venous Catheter ☐ Other: Access Location ☐ Arm ☐ Leg ☐ Chest ☐L ☐ R Additional Details:
Secondary Access	☐ AV Fistula ☐ AV Graft ☐ Central Venous Catheter ☐ Other: Access Location ☐ Arm ☐ Leg ☐ Chest ☐L ☐ R Additional Details:
PD Catheter	☐ Yes ☐ No
Special Considerations for Cannulation	Self Cannulation: ☐ Yes ☐ No Partner Cannulation: ☐ Yes ☐ No Other considerations:
Needle Type and Size	Type: _____ Size: _____
Central Line Locking Agent and Volumes	Locking Agent: _____ Volume: _____mL
Local or Topical Anesthetic	☐ Yes ☐ No Type:

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Medical History – Can attach a summary from the Electronic Medical Record

Diabetes Mellitus: ☐ Yes ☐ No Additional Information:	Insulin Dependant: ☐ Yes ☐ No
List of Current Medications:	☐ Attached
Known Allergies:	
Intravenous medications required during dialysis: **List must be brought by patient*	
Oral medications required during dialysis: **List must be brought by patient*	

Patient-Specific Needs

Mobility Needs:	☐ Independent ☐ Requires assistance from one person ☐ Requires assistance from more than one person ☐ Fall Risk
Accessibility:	☐ Wheelchair ☐ Vision Loss ☐ Assisted Devices (i.e. language and/or interpretation devices: _____ ☐ Communication Difficulties ☐ Hearing Loss ☐ Other:
Preferred Dialysis Position	☐ Patient can sit in a chair ☐ Patient can only use the bed **(provide reason below):**

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Infection & Immunity Information

Infection and Immunity

Isolation Requirements:	☐ Yes ☐ No Details:
History of Other Infections	☐ ESBL ☐ CPO ☐ Other: _____
Additional Information	

Travel-Specific & Site-Specific Information

Travel-Specific Information

Reason for visit:	
Temporary Address While Travelling:	Street: _____ City: _____ Postal Code: _____
Local contact while travelling:	Name: _____ Phone Number: _____ Address: _____
Mode of Transportation:	☐ Self Transportation ☐ Transport provided by contact of patient ☐ Other: _____
Emergency plans during travel: Emergency contact during travel:	

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Other Comments: