CONFIDENTIAL

SAIPAN RENAL CARE
Dialysis Facility

PATIENT INTAKE FORM

PATIENT INFORMATION

Name of Patient: _____ DOB: _____

Gender: ☐ Male ☐ Female Age: _____

Mailing Address:

_____

Physical Address:

_____

Tel No.: _____ Email: _____

Emergency Contact Person: _____Tel No.: _____

Insurance Information *(provide a copy of insurance cards both front & back section)*

☐ Medicare
☐ Medicaid
☐ Other: _____

First HD Treatment: _____ Name of Facility: _____

Saipan Renal Care Treatment Start Date: _____

Diabetes: ☐ Yes ☐ No

Diagnosis: ☐ ESRD ☐ Acute Renal Failure

ESRD Cause (If known) _____

Type/Modality: ☐ In-Center HD ☐ Other: _____

Treatment Schedule: ☐ M/W/F ☐ T/TH/S ☐ AM ☐ PM

Treatment Duration: _____ Hours _____ Minutes

Access Type: ☐ Catheter ☐ PD Catheter ☐ Fistula ☐ Graft

P.O. Box 500170 ● 7014 Ilamefisch Place • Beach Road Chalan Laulau ● Saipan, MP 96950
Tel. No. (670) 234.4747 ● Fax. No. (670) 235.2273
Email: saipanrenalcare.cnmi@gmail.com

Date Access Inserted: _____

Hep B Antigen: ☐ Negative ☐ Positive ☐ Unknown ☐ Testing in Progress

Does Patient have Tracheostomy? ☐ Yes ☐ No

Preferred Treatment Seating: ☐ Chair ☐ Bed

PRIOR TO ADMISSION FOR TREATMENT

- ☐ Allergies: Type: _____
- ☐ Hep B Antigen* (*HBsAg*) (*drawn within 30 days*): Date drawn: _____
- ☐ Hep B Surface Antibody* (*HBsAb)* (*drawn within 12 months*):
  Date drawn: _____ (**CMS CfC, Hep B results are required prior to treatment)*
- ☐ Medication Records
- ☐ Dialysis Flow Sheets (*up to three*)
- ☐ Current Patient History (*atleast within the last 12-months*)
- ☐ Monthly Lab Orders *(at least the three most current*)
- ☐ Vaccination Records
- ☐ Hepatitis Status (within 30 days) including Hepatitis C results
- ☐ Any PPD or Chest Examination (*within the last 90 days*)? Date: _____
- ☐ Name of Social Worker: _____
- ☐ Medical/Treatment Directives (*provided*) ☐ Yes ☐ No
- ☐ Physician Dialysis Order

Comments:

_____

_____

_____

_____

(Please draw a map to your residence and identify landmarks & buildings)

FOR OFFICIAL USE ONLY: Patient Reference Number: _____

Name of Receiving Staff: _____ Date: _____

Referred to: ☐ Medical Director ☐ Nurse Supervisor ☐ Patient File

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PATIENT TRANSFER FORM

Transfer From: _____ Date: _____

Transfer To: _____

This letter certifies that _____ wishes to transfer to _____.

Reason for transfer:

_____ _____

Signature Date

_____ _____

Witness Date

_____ _____

Nephrologist/Provider Date

Name: _____

DOB: _____

Hospital Number: _____

SAIPAN RENAL CARE
Dialysis Facility

PATIENT RECEIVING FORM

Receiving Facility: _____ Date: _____

Transferring Facility: _____

This Patient Receiving Form certifies that _____

was transferred and received from _____.

Reason for Transfer:

_____ _____

Signature Date

_____ _____

Witness Date

_____ _____

Nephrologist/Provider Date

Name: _____

DOB: _____

Hospital Number: _____