Lower Manhattan Dialysis Center INC
323 East 34th Street
New York, New York, 10016
Telephone # 212-889-1082
Fax # 212-685-6480

Thank you for your interest in transient dialysis at Lower Manhattan Dialysis Center. Before we can consider your request, we require the following information.

1. Current History and Physical (within 90 days of being treated)
2. Lab results including Hepatitis B Surface antibody quantitative (numerical value), Hepatitis B Surface Antigen, Hepatitis C Antibody. These must be drawn within 30 days of the treatment date at our facility.
3. Medication list (within 1 month)
4. Chest x-ray or PPD or Quantiferon gold within one (1) month of treatment date. (if PPD or Quantiferon is positive, chest x-ray is required in addition).
5. EKG within (3) three months of treatment date.
6. Three (3) most recent flow sheets (also please have the dialysis center give you copies of the most recent flow sheets to bring with you). Completed Transient Transfer Form (enclosed)
7. Signed Authorization for treatment form.
8. Please make sure that all patient info is in English and signed by doctor.
9. Please do not plan to treat on the day you arrive or the day of your departure.

This information can be emailed to Dianna@lowermanhattandialysis.com or faxed to 212-685-6480. All items must be received before our medical staff can review the chart one week in advance.

Payment of fee by Travelers check, Major Credit Card or cash is required prior to the first treatment, or on arrival. PERSONAL CHECKS WILL NOT BE ACCEPTED.

I will be in touch with you to arrange a schedule time once your medical and financial information has been approved. Please feel free to call me if there are any questions. We look forward to your visit with us.

Sincerely yours

……..…….
Dianna Mercurius
Patient Services Coordinator
Lower Manhattan Dialysis Center Inc

LOWER MANHATTAN DIALYSIS CENTER, INC 323 EAST 34 STREET, NEW YORK, NY 10016 TELEPHONE # 212-889-1082 FAX # 212-685-6480

TRANSIENT TRANSFER FORM

PATIENT NAME: …… AGE:

…… HEIGHT: …….. DATE OF BIRTH:

……..

HOME ADDRESS:

……

…… HOME PHONE #: …… CELL PHONE #:

……..

REFFERING DIALYSIS UNIT:
……TEL#……..……

ADDRESS WHILE VISITING IN AREA:
……..

LOCAL PHONE #: …… DESIRED DATES FOR TREATMENT:
……

HAVE YOU EVER HAD DIALYSIS IN THE USA? YES NO

WHERE?:
……
……..

MEDICAL HISTORY

PRIMARY DIAGNOSIS:
……
……

SECONDARY DIAGNOSIS:
……
…….

OTHER MEDICAL PROBLEMS:

……
.

……
…….. ALLERGIES:
……
…….

DIALYSIS

DATE OF INITIAL TREATMENT:

……

FREQUENCY OF DIALYSIS PER WEEK……

DURATION OF TREATMENT:

……
…..

AVERAGE BLOOD FLOW:

……
……..

DIALYZER:

……
…….

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HEPARIN DOSAGE: BOLUS……HOURLY MAINTENANCE……

POTASSIUM DIALYSATE BATH: 1K, 2K, OR 3K…….

TARGET WEIGHT: …… LAST POST WEIGHT: …… DATE: ……

COMPLICATIONS DURING TREATMENT:
……

……
……..

VASCULAR ACCESS:

NEEDLE GAUGE:…… LOCATION & ACCESS TYPE:
……..

STATUS OF CURRENT ACCESS:
……..

IN-CENTER MEDICATIONS:

EPOGEN: DOSAGE……UNITS
FREQUENCY……..

VENOFER: DOSAGE……..MG FREQUENCY……..

CALCITRIOL: DOSAGE……MCG FREQUENCY……..

HECTOROL: DOSAGE……..MCG

FREQUENCY……..

SENSIPAR: DOSAGE……..MCG

FREQUENCY……..

LABS:

POTASSIUM: ……..……..DATE: ……

HEMOGLOBIN or HEMATOCRIT: ……..DATE: ……

KT/V or URR: ……..…DATE:……

LOWER MANHATTAN DIALYSIS CENTER, INC

PATIENT AUTHORIZATION FOR DIALYSIS TREATMENT

AND RELATED CARE

PATIENT NAME: _____

I hereby authorize Lower Manhattan Dialysis Center, and its physicians and patient care staff to perform and administer dialysis treatments and procedures, intravenous medications, and to render all other medically necessary procedures and services on me.

DATE:_____ SIGNED: _____

(PATIENT)

WITNESS: _____ SIGNED: _____

(NEAREST OF KIN & RELATIONSHIP)