



Universal Kidney Centers

Ft. Lauderdale 4875 NE 20 th Terrace Ft. Lauderdale, FL 33308 Tel. (954) 958-9300 Fax (954) 958-9223	Pembroke Pines 18004 NW 6 th St. Pembroke Pines, FL 33029 Tel. (954) 433-9400 Fax. (954) 430-3300	Boynton Beach 4895 Windward Passage Boynton Beach, FL 33436 Tel. (561) 740-1981 Fax (561) 732-8288	Davie 11570 W. State Rd. 84 Davie, FL 33325 Tel. (954) 727-9100 Fax (954) 727-9880	Margate 2800 N. State Road 7 Margate, FL 33063 Tel. (954) 968 - 8500 FAX (954) 957-8700
--	---	---	---	--

Transient Checklist

The following medical records (last 30 days) are required on all patient(s) transferring to Universal Kidney Center of

- Boynton Beach
- Davie
- Fort Lauderdale
- Pembroke Pines
- Margate

Please FAX documents As Soon As Possible

- Physician's Hemodialysis Orders
- Current History & Physical and Discharge Summary
- Last three treatment flowsheets
- Current Medication List
- Current Lab Reports (Hematology, Chemistry, & other Lab Data)
- Current HbsAg /Hepatitis Profile
- Copies of Insurance cards (front & back) (Primary & Secondary)
- Local Address and Phone Number
- Complete Hemodialysis Admission form (Enclosed)
- Chest X-Ray
- EKG copy

*****NOTICE*****

Please Inform the patients that an office visit is required within the first week of arrival for treatment.

Monthly Doctors Fee

\$ 10.00 Doctors monitoring fee every treatment.



Universal Kidney Centers

Patient Name:

Ft. Lauderdale 4875 NE 20 th Terrace Ft. Lauderdale, FL 33308 Tel. (954) 958-9300 Fax (954) 958-9223	Pembroke Pines 18004 NW 6 th St. Pembroke Pines, FL 33029 Tel. (954) 433-9400 Fax. (954) 430-3300	Boynton Beach 4895 Windward Dr. Boynton Beach, FL 33436 Tel. (561) 740-1981 Fax (561) 732-8288	Davie 11570 W. State Rd. 84 Davie, FL 33325 Tel. (954) 727-9100 Fax (954) 727-9880	Margate 2800 N. State Road 7 Margate, FL 33063 Tel. (954) 968-8500 FAX (954) 957 08700
--	--	---	---	---

**Please fill out
and fax to :**

- Boynton Beach** **Davie** **Pembroke Pines**
 Fort Lauderdale **Margate**

Patient Information

Patient Name:		DOB:	Sex: M / F	Marital Status:
Street Address:			Contact Number:	
City:		Apt #:	State:	Zip Code:
Cell Number:	Work Number:			
OHIP / RAMQ #:		Co-Insurance:		
Primary ESRD Diagnoses:	Secondary ESRD Diagnoses:			
Date of first Dialysis:		Preferred Time:		
Total # of Treatments:				

Referring Dialysis Unit Information

Referring Unit Name:	Contact Nurse:		
Phone Number:	Fax Number:		
Primary Nephrologist:	Social Worker:		
Nephrologist Address:	City:	State:	Zip:
Nephrologist office Number:	Fax Number:		
Emergency Patient Contact Name:	Relationship:		
Home Phone Number:	Cell Phone Number:		

Local Residence Information (Transient City)

Local Address/Hotel:	Phone Number:
Emergency Contact:	Number:

Transient Unit: _____	Number: _____
------------------------------	----------------------

Insurance Carrier Name: _____
Policy Number: _____
Mailing Address: _____



Universal Kidney Centers

Treatment Information

Patient Name: _____

Ft. Lauderdale 4875 NE 20 th Terrace Ft. Lauderdale, FL 33308 Tel. (954) 958-9300 Fax (954) 958-9223	Margate 2800 N. State Rd. 7 Margate, FL 33063 Tel. (954) 968-8500 FAX (954) 957 -8700	Pembroke Pines 18004 NW 6 th St. Pembroke Pines, FL 33029 Tel. (954) 433-9400 Fax. (954) 430-3300	Boynton Beach 4895 Windward Dr. Boynton Beach, FL 33436 Tel. (561) 740-1981 Fax (561) 732-8288	Davie 11570 W. State Rd. 84 Davie, FL 33325 Tel. (954) 727-9100 Fax (954) 727-9880
--	--	---	---	---

<input type="checkbox"/> Home	<input type="checkbox"/> In-Center	<input type="checkbox"/> Hemo	<input type="checkbox"/> Self Care	<input type="checkbox"/> Staff Assisted
-------------------------------	------------------------------------	-------------------------------	------------------------------------	---

Treatment Type:	<input type="checkbox"/> Conventional	<input type="checkbox"/> High Flux	<input type="checkbox"/> High Efficiency	Volumetric: Y / N
------------------------	---------------------------------------	------------------------------------	--	-------------------

Dry Weight:	_____	Blood Flow:	_____	Dialysate Flow:		
Times Per Week:		Prescribed Time:				
Dialysate Rx:	K+	CA++	Dextrose	Sodium	Bicarb	Acetate
Dialyzer Type:				Profile:		
Heparization Method:				Total Units:		
If Pump DC: Hr / Min Pre-Treatment Termination						

Vascular Access			
Vascular Access:	Type:	Location:	Flow Direction:
Local Anesthetic: Y / N	Usual Venous Pressure:		Diagram:
Other cannulation considerations: (e.g. Needle gauge, self- cannulation) 14 gauge , 15 gauge, 16 gauge or 17 gauge			
Does the patient use Benadryl during tx. ?			
Vascular Catheter special flush instructions:			
Buttonhole Technique		Yes / No	
Prolonged Bleeding Post Treatment		Yes / No	
Hepatitis B status: Neg / Pos		Date Tested: _____ Hepatitis C Neg / Pos Date Tested: _____	
Any Food or Drug Allergy:			
Legally Blind		Yes / No	

Hard Of Hearing	Yes / No
Will Need Assistance in transferring	Yes / No
Routine Lab. Works:	
Any Special Care we Need to Know:	

First Dialysis Day in Florida: _____ **Last Dalysis Day in Florida:** _____