Rogosin Institute

Admissions Intake Form

P: 1-888-ROGOSIN (1-888-764-6746) F: 646-317-0516

Patient Name: ______________________________ **Date:**_____/_____/_____

Admission Type: (Please check)

☐ **New Admission** ☐ **Transfer In** ☐ **Readmission (past 30 days)** ☐ **Resume (within 30 days)** ☐ **Transient**

Contact Name: ____________ Contact Phone: ____________ Contact E-mail: ____________

Hospital/Dialysis Unit/Practice: ______________________________

Primary Nephrologist (if known): ____________ Nephrologist Phone (if known): ____________

STEP 1: SCHEDULE A PATIENT

Please COMPLETE this FORM and FAX it along with patient's FACE SHEET (insurance & demographics.)

Requested Facility or Zip Code:__________________

Anticipated Start Date:___________________

Preferred Schedule: ☐ **MWF** ☐ **TTHS** ☐ **AM** ☐ **PM**

Patient is Flexible: ☐

STEP 2: FINALIZE PLACEMENT

To CONFIRM ADMISSION, please FAX the following:

- Last 3 HD treatment records (if available)
- Current history & physical (within last year)
- PPD (30 days), Chest X-Ray (90 days) or QUANTIFERON
- Albumin___, Creatinine___, Hemoglobin____
- Most recent monthly lab results (within 30 days)
- Most recent Hepatitis Panel
  Hep B Antigen (HBsAG) (within 30 days)
  Hep B Surface Antibody (HBsAB) (within 12 months)
  Hep B Total Core Antibody (HBcAB) (within 12 months)
- Psychosocial Assessment
- COVID 19 PCR or Rapid Antigen Result **or** Physician/ Advanced Practice Provider note stating symptom free of COVID 19; within 3-5 days prior to admission

IF AVAILABLE:

- Discharge summary sheet
- Consultations
- Access/associated Operative Reports
- EKG
- 2728 (if applicable)
- COVID 19 Vaccination Record

PATIENT CARE

First Date of Dialysis Ever:_______/_______/_______

Treatment Duration:____ **hrs** ____ **mins** **Frequency:**_______

MODALITY:

☐ In-Center Hemo

☐ Home Hemo

☐ PD

DIAGNOSIS:

☐ ESRD

☐ Acute Renal Failure

ACCESS TYPE: ☐ Graft ☐ Fistula ☐ CVC

Date of access placement:______/______/______

Date access first used:______/______/______

Other:______________________

SPECIAL NEEDS:

Does the patient have a tracheostomy? ☐ Y ☐ N

Require treatment in bed? ☐ Y ☐ N

Other special needs? ________________________

AMBULATION STATUS:

☐ Ambulatory without assistance

☐ Ambulatory with device (walker, cane, etc.)

☐ Requires stretcher transport

MODE OF TRANSPORTATION:____________________

Notes:

***Please use this page as your fax cover sheet.**