

This form is intended to facilitate the prompt assessment of a patient's eligibility to receive coverage for Intradialytic or Intraperitoneal Parenteral Nutrition. Please have the complete information available when you call us to refer your patient for therapy.

<b>Dialysis Center:</b>					
<b>Address:</b>		<b>City</b>		<b>State</b>	
<b>Referred by:</b>		<b>Phone</b>		<b>Referred Date:</b>	
<b>Phone</b>		<b>Fax</b>		<b>Referred Date:</b>	
<b>PATIENT INFORMATION</b>		<input type="checkbox"/> IDPN <input type="checkbox"/> IPN		<b>NutrePletion RD:</b>	
Patient Name:		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Race:	
Address		Home Phone #		DOB	
City		State		Zip	
Physician		NPI #		Preferred Pt Phone # (for Pharmacy contact)	
Medicare No.		Medicaid No.		State	
Other Insurance		ID No.		Group No.	
Address		Phone			
Policy Holder, if other than patient:		Date of 1 <sup>st</sup> dialysis:			
Insured SS#				DOB	
<b>Emergency contact:</b>		<b>Phone:</b>		<b>Relation:</b>	
<b>MEDICAL INFORMATION</b>					
Past Medical Hx (including all known GI diseases and surgeries, and, if available, please attach copies of diagnostic test results / reports substantiating the above):					
Meds prescribed to treat GI dysfunction and results:					
Medication Allergies:					
Food Allergies:		Body Frame: <input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large			
Height	Current EDW	Usual Weight	SBW	ABW _____ <input type="checkbox"/> For Amputation <input type="checkbox"/> For Needs	
Monthly weights over last 6 months (including dates)		/ /	/ /	/ /	/ /
Albumin: Please include dates and values for last 3-6 months <u>Attach most recent labwork</u>		/ /	/ /	/ /	/ /
<b>Most Recent lab levels (including date):</b>	<b>TG :</b> ( / / )	<b>Cholesterol:</b> ( / / )	<b>KT/V:</b> ( / / )	<b>URR:</b> ( / / )	
	<b>Phos:</b> ( / / )	<b>K:</b> ( / / )	<b>nPCR:</b> ( / / )	<b>TIBC:</b> ( / / )	
	<b>HbA1C:</b> ( / / )	<b>Mg:</b> ( / / )	<b>Other:</b> ( / / )		
Estimated average daily oral intake:		Calories		Protein (g)	
Estimated daily percentage from oral supplements and/or TF		Calories		Protein (g)	
Estimated needs:		Calories		Protein (g)	
Explain attempts made to increase oral caloric intake and results (i.e. supplements, etc.):					
<b>Hemodialysis schedule:</b>		<b>Days</b>		<b>Time of Shift</b>	
Peritoneal Dialysis regimen:		Exchanges / day		cc / exchange	
<input type="checkbox"/> CAPD <input type="checkbox"/> CCPD				% dextrose for exchanges	
				% dextrose for exchanges	
Type of P.D. medical system:		Baxter Fresenius		Other: _____	
Additional Comments					