

This form is intended to facilitate the prompt assessment of a patient's eligibility to receive coverage for intradialytic parenteral nutrition (IDPN) or intraperitoneal nutrition (IPN). Please fill out this form completely or provide us with demographic and insurance data as a first step.

Date referred: _____

PATIENT INFORMATION						
IDPN <input type="checkbox"/> - In center _____ In home _____		IPN <input type="checkbox"/>				
Patient name (Last) _____		Patient name (First) _____		NutrePletion RD _____		
Address _____			Dialysis center _____			
City _____		State _____	Zip _____		Address _____	
Phone _____		Sex _____	Race _____		City _____	
DOB _____		SS # _____		State _____		
Insurance information _____			Referred by _____			
Medicare # _____		Medicaid # _____		Physician name _____		
Other _____		ID # _____	Group # _____		Date of first dialysis _____	
(Please fax copy of insurance cards)			Emergency contact _____	Phone _____	Relation _____	

MEDICAL INFORMATION					
Please fax the following with referral: <input type="checkbox"/> Current medication list <input type="checkbox"/> Three months' labs <input type="checkbox"/> Problem list/Dx					
Additional Medical Hx: _____					
Allergies _____					
Medications: _____					
Food: _____					
Body frame: <input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large			Amputation(s) _____		
Height: _____		EDW: _____	Usual Weight: _____		Date of amputation(s): _____
Monthly weights last 6 months(include dates)					
Albumin last 3-6 months (dates & values)					
Nutritional needs: Estimated average daily intake: Calories: _____ Protein: _____ (Does this include oral supplements or TF? _____) Explain attempts made to increase oral caloric intake and results (i.e., supplements, etc.): _____					
HD schedule: _____ Days: _____ Shift: _____ Start time: _____ Length of dialysis treatment: _____					
PD regimen		Exchanges/day:		cc/exchange	
PD type: CAPD/CCPD		% dextrose for _____ exchanges		____ % dextrose for _____ exchanges	
Type of PD medical system:		Luer Lock: Yes <input type="checkbox"/> No <input type="checkbox"/>		Calcium: Low (2.5) <input type="checkbox"/> Standard (3.5) <input type="checkbox"/>	

Additional comments: _____