 **HARRISON DIALYSIS, L.L.C**

**CONSENT FOR DIALYSIS AND RELATED TREATMENTS**

**GENERAL:**

I give my consent for Harrison Dialysis and Physicians to prescribe, direct, and provide dialysis treatment and other health care that I need because of my kidney failure. This care will include, but is not limited to:

1. Dialysis treatments prescribed, directed and supported by my doctor and other in the Harrison Dialysis healthcare team.
2. My participation, to the best of my ability, in planning and carrying out my treatment.
3. Sharing of my health records and health information only with people involved in my health care, so that my health care can be better coordinated.

**DRUGS AND OTHER TREATMENTS:**

**I understand that the physician may prescribe drugs that I need as part of my treatment. These drugs may be taken by me at home or given to me while I am at the dialysis clinic, by my doctor or members of the health care team. If I choose to dialyze at home, I or my dialysis assistant may give some of these medications at home.**

**Also I understand that small amounts of blood will be drawn for blood tests as directed by my doctor.**

**LAB:**

**I understand that, based on my medical condition when I arrive at the dialysis facility, the physician may direct members of the health care team to take small abound of blood for testing.**

**SIGNATURE OF CONSENT:**

**I have read this consent form (or it has been read to me) and I understand it. The form has been fully explained to me by a member of the health care profession. I have had a chance to ask questions, and all my questions have been answered to my satisfaction. I understand that I may withdraw my consent at any time by informing the Charge Nurse of Harrison Dialysis.**

**I voluntarily consent to the dialysis treatment I have selected and authorize Harrison Dialysis to provide these services to me.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s name (Print) Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Signature**

**If patient is unable to sign:**

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**Patient’s Representative Relationship**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness**



**HARRISON DIALYSIS**

**1409 GLADDEN ST**

**HARRISON, AR 72601**

**PHONE: 870-204-6683, FAX: 870-204-6686**

**TO THE TRAVEL COORDINATOR**:

Thank you for inquiring about travel arrangements for your patient. We are happy to have visiting patients and during the “season”, frequently accommodate as many as twenty visitors a week. Because of this volume, we count on you to ensure that we have all of the information we need to provide good treatment to your patient. Although some of this information may seem excessive or unnecessary, we request what is required by our state licensing agency or more importantly, what we may need in the event of an emergency involving your patient. The physician’s statement of stability provides us with a “heads up” for those patients who may be at a higher risk for developing problems while out of town. We know that sometimes patients will insist on taking a vacation in spite of their physician’s recommendations against travel. If we know that, we can keep a closer eye on them while they are here.

We do our best to arrange your patient’s treatment schedule so that they can take full advantage of their time here. However, we also maintain a regular patient roster and cannot ask them to disrupt their schedules for nine months of the year to accommodate visitors. Most of the shows have more than one show scheduled each day. Patients can arrange their show schedule more easily than they think, and we encourage them to check show schedules on-line and by calling the theatres. Most every visitor wants an early morning spot, as do most of our patients. However, if a patient is in the hospital or is not here for some reason, we will call someone to fill that spot. For that reason, it is very important that we have a means of contacting the visiting patient. Please provide us with a working cell phone number and ask the patient to keep it on.

Because we have so many visitors, it is impossible for us to call on each visiting patient to determine if prior authorization is require and to then obtain prior authorization. We, therefore, ask that the home unit bear that responsibility. If prior authorization is required for an insurance or VA patient and not provided to us by the home unit, the patient will unfortunately be required to pay for his or her treatment. If prior authorization is not required you may state that on the fax cover sheet. **PLEASE** ensure that you send this information to us two weeks prior to the scheduled visit.

We must have the requested information at least one week prior to the patient’s visit. We do not require the most recent flow sheets. For example, if your patient is scheduled for the second week of the month, we can the flow sheets from the last week of the previous month. We must have the charts to our physician for review and signatures by Wednesday of the week prior to the scheduled visit. We do not require labs from the month of the visit- three months prior to the visit are sufficient. For example send January, February, March for an April visit.

Please do not hesitate to contact is if you have any questions or concerns. We want this to be a time for the patient to relax and have some fun. You can help us do that by preparing your patients and sending the necessary information. **We do not schedule a chair for a patient until all of the requested information is received!** Thank you for your help in making vacation a fun experience for your patient and we look forward to assisting you and your patient during their visit.

**IMPORTANT INFORMATION**

**HARRISON DIALYSIS**

**1409 GLADDEN ST**

**HARRISON, AR 72601**

**PHONE: 870-204-6683, FAX: 870-204-6686**

**TO THE VISITING PATIENT**:

Thank you for your interest in visiting Harrison and our dialysis unit. We are very happy to have visiting patients and look forward to seeing you. Included here is some information that may be useful as you prepare to visit.

We **CANNOT** give out specific treatment times until the day before your visit. The reason for this is that there are frequent changes in the schedule due to patient hospitalizations, new patients who must be schedule at the last minute, or other visiting patients who may have cancelled their visit for a variety of reasons. We therefore are not able to predict exactly which time slot may be available. We understand that most visitors may want to schedule shows ahead of time or may want an early treatment time. However, we have a regular patient load and cannot displace them from a time slot for a visitor. We hope that you can put yourself in their place and understand that, with sometimes as many as twenty visitors a week during the busy season, it would be very disruptive to their lives to be moved around to accommodate visitors. **Call 870-204-6683 and speak with the Charge Nurse or the Facility Manager. There are two other dialysis units about 40 miles from Harrison, Branson Dialysis at 417-335-8288 and Branson Kidney Center 417-272-0222. Another helpful number is Cox Medical Center Branson (hospital) at 417-335-7000, which can support dialysis.**

In the unlikely event that we need to change your scheduled time, it is important that you provide us with a cell phone number or a phone number where you will be staying. **Occasionally an early morning patient is hospitalized or unable to come at their time. We can then call and offer you that time slot, if we can contact you.**

You will need to bring whatever blankets or pillows you need during your treatment. We are unable to keep a supply available due to infection control issues. You will have a television available to you that will require headphones to hear with. We do allow eating in the unit and suggest you bring something if you are used to eating at the time of your scheduled treatment. We can provide you with ice during your treatment; however, we cannot keep food in the refrigerator or heat food in the microwave for you.

We are located at 1409 Gladden St in Harrison and a map has been provided to your travel coordinator. Please let us know if you require additional information and we look forward to seeing you. Please keep in mind that Harrison traffic can be busy, it may benefit you to pre-drive your route to determine how long it will take you to get to the dialysis unit.



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| Patient Information | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient Name: | | | | | | | | | | | | DOB: / / | | | | | | | | Sex: | | | | | | Marital Status: | | |
| Parent or Legal Guardian (if minor): | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: City: State: ZIP: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Phone: | Cell | | | | | | | Home | | | | | | | | | | | | |  | | | | | | | |
| SSN: | | | | | | HIC#: | | | | | | | | | | | | | | Date 1st Dialysis: / / | | | | | | | | |
| ESRD Diagnosis: | | | Primary | | | | | | | | | | | | | | Secondary | | | | | | | | | | | |
| Treatment Dates Requested: \_\_\_\_/\_\_\_\_/\_\_\_ to \_\_\_/\_\_\_\_/\_\_\_\_ | | | | | | | | | | | | | | | | Total # of Treatments | | | | | | | | | | | | |
| Referring Dialysis Unit Information | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Referring Unit Name | | | | | | | | | | | | | | | Phone | | | | | | | | | | Fax | | | |
| Contact Nurse: | | | | | | | | | | | | Social Worker: | | | | | | | | | | | | | | | | |
| Primary Nephrologist | | | | | | | | | Phone: | | | | | | | | | | | Fax: | | | | | | | | |
| Emergency Contact | | | | | | | | | | | | Relationship: | | | | | | | | | | | | | | | | |
| Home Phone | | | | | | Cell Phone | | | | | | | | | | | | | | Work Phone | | | | | | | | |
| **Local Residence Information (Transient City)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Local Address or Hotel: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Local Emergency Contact: | | | | | | | | | | Relationship | | | | | | | | | | | | Phone | | | | | | |
| Dates Patient is planning on being in Harrison \_\_\_/\_\_\_/\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | Kt/V=\_\_\_\_\_\_\_ on \_\_\_/\_\_\_/\_\_\_ | | | | | | |
| **Home Facility Current Treatment Orders** | | | | | | | | | | | **Harrison Dialysis Orders** | | | | | | | | | | | | | | | | | |
| In-Center Hemo  Self Care or Home Hemodialysis  Staff Assisted  **Last Kt/V = \_\_\_\_\_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_** | | | | | | | | | | | Bath:\_\_\_\_K | | | | | | | BFR:\_\_\_\_\_\_ | | | | | Time:\_\_\_\_\_ | | | | | TW:\_\_\_\_\_\_ |
| Heparin:\_\_\_\_\_\_ unit bolus | | | | | | | | Dialyzer : F160  \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | Needle GA:\_\_\_\_ | |
| Dialyzer | | Treatment Time:\_\_\_\_\_\_\_\_ | | | Access:\_\_\_\_\_\_\_\_\_\_  Site:\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | **Harrison Medication orders** | | | | | | | | | | | | | | | | | |
| Blood Flow Rate | | Height: cm | | | Target weight kg | | | | | | ESA: \_\_\_\_\_\_\_\_ u q \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HGB: | | | | | | | | | | | | | | | | | |
| Heparinization: Total dose | | Needle Gauge:\_\_\_\_\_\_  Button Hole Y N | | | | | Bath: | | | | Ferrlecit: / Prior month HGB: | | | | | | | | | | | | | | | | | |
| ESA units Q\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | Other Meds: | | | | | | | | | | | | | | | | | |
| Iron mg Q\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | If not on 2K, what were last 2 potassium labs?  \_\_\_/\_\_\_/\_\_\_ = \_\_\_\_\_\_ ; \_\_\_/\_\_\_/\_\_\_ = \_\_\_\_\_\_\_\_\_\_\_  Last 3 Post Weights: \_\_\_\_\_\_\_\_\_; \_\_\_\_\_\_\_\_\_\_; \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | |
| Antibiotics | | | | | | | | | | |
| Other | | | | | | | | | | |
| Allergies | | | | | | | | | | | Harrison Dialysis MD signature  Date / / | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | |
| **Code Status**  **Full**  **DNR** | | | | | | | | | | | Diabetic Yes  No  Insulin Dependent  Yes  No | | | | | | | | | | | | | | | | | |
| **Patient Specific Information**  **(Synopsis of unique characteristics of patient’s treatments)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s trends and usual response to treatment: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Interdialytic wt. gains #kg | | | | | | | | Usual B/P support methods | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Unusual reactions or needs: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Special needs or circumstances relative to transient visit: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Intradialytic Monitoring**  **If applicable. Otherwise note “NA”** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Special Labs: | | | | | | | | | | | | | Blood Glucose: | | | | | | | | | | | | | | | |
| Intradialytic treatments: | | | | Dressing | | | | | | | | | O2 | | | | | | | | | | | Other | | | | |
| Mobility:  Ambulatory  Non-ambulatory  Ambulatory with assist  Transfer independently  Amputee Single Double | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fluid restriction: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Enclosures: Check indicates information sent from home facility** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Standing orders | | | | | | | | | | | | | Advance Directive, if applicable | | | | | | | | | | | | | | | |
| Completed ESRD transient hemodialysis form | | | | | | | | | | | | | Current H & P (within past 12 months) | | | | | | | | | | | | | | | |
| Medication record (home and in-center) | | | | | | | | | | | | | 3 flow sheets from week prior to visit date | | | | | | | | | | | | | | | |
| Interdisciplinary Plan of Care (within 12 months) | | | | | | | | | | | | | Multidisciplinary Assessment (within 12 months) | | | | | | | | | | | | | | | |
| MD progress notes (Last monthly note) | | | | | | | | | | | | | Visiting Patient Policy – signed by patient | | | | | | | | | | | | | | | |
| PPD/Chest x-ray (within past 12 months) | | | | | | | | | | | | | Laboratory profile x 2 months prior to visit date | | | | | | | | | | | | | | | |
| HbsAB Status  Positive  Negative date  \_\_\_\_/\_\_\_\_/\_\_\_\_ (within 12 months) | | | | | | | | | | | | | HbsAg status must be negative and completed within 30 days of visit | | | | | | | | | | | | | | | |
| Insurance cards – front & back (Must be Readable)  Primary  Secondary | | | | | | | | | | | | | | CMS 2728 | | | | | | | | | | | | | | |
| Demographics | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Prior Authorization completed, (must be obtained by home unit at least 2 weeks prior to visit date) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Special Instructions** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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