



Dear Dialysis Facility Staff,

Thank you for referring your patient for dialysis services at Nephrology, Inc.

It is the policy of Nephrology, Inc. to obtain the following information before arrangements can be made:

1. Completed Patient Information Packet
2. Provide enlarged, legible copies of all insurance cards
3. HCFA - 2728 Form
4. Advanced directives (if applicable)
5. Dialysis orders
6. Code status
7. Chest X-ray or PPD (within one year)
8. EKG, if available (within one year)
9. Current medication list
10. Recent history and physical (within 1 year)
11. Last 3 dialysis treatment records
12. Lab profiles within the last 30 days
13. HbsAg STATUS within 30 days
14. HbsAb STATUS within 1 year
15. Hep B Core Antibody report
16. Current Plan of Care
17. Most recent Psychosocial Update
18. Most recent Dietary Assessment
19. Most recent comprehensive assessment

Our billing department will verify insurance coverage and calculate any costs the patient may have. Payment is required **prior** to receiving treatment. If payment is required, please have it mailed to:

Nephrology, Inc.
250 East Day Road, Suite 300
Mishawaka, Indiana 46545

We also accept credit card payments by calling (574) 273-6787 Extension 7309.

Patients may be scheduled at any one of our five units located in Elkhart, LaPorte, Mishawaka, Plymouth, or South Bend. Notification of unit location and treatment time will be given prior to arrival.

Sincerely,
Sarah Kazee
Dialysis Intake Coordinator
Nephrology, Inc.
700 Waterbury Park Drive
Elkhart, Indiana 46517

Phone: (574) 294-4444
Fax: (574) 295-7400



Patient Information Packet

Patient Name _____ DOB _____ Sex _____

Marital Status _____ Social Security Number _____

Parent/Legal Guardian _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Visiting Address _____

Visiting City _____ Visiting State _____ Visiting Zip Code _____

Visiting Phone _____

Date of First Dialysis _____

ESRD Diagnosis: Primary _____ Secondary _____

Emergency Contact _____

Home Phone _____ Work Phone _____

Insurance Information

Primary Insurance _____ Policy Number _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Group Number _____

Secondary Insurance _____ Policy Number _____

Address _____



City _____ State _____ Zip Code _____

Phone Number _____ Group Number _____

**Please include all needed referral information*

Referring Dialysis Facility Information

Referring Facility Name _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____

Primary Nephrologist _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____

Treatment Dates Requested (Not Guaranteed) _____

Preferred Time (Not Guaranteed) _____

Special Instructions (Include transplant list information if applicable)

Signature of Person Completing Form

Phone Number



Visiting Patient Physician Orders

Patient Name: _____

SSN: _____ DOB: _____ Sex: _____

Treatment Orders

NOTE: Asterisk (*) fields are required - failure to complete this form will result in form being returned to you & delay of patient acceptance.

DIALYSATE TEMP*: _____ BICARBONATE* (19-42): _____

DIALYSATE BATH* (circle one) 2K 2CA 3K 2CA (*We do not provide other dialysate baths*)

DIALYZER: WILL BE EXELTRA 150

SODIUM* 130 135 140 145 150 155 (circle one) or LINEAR: start _____ end _____

LENGTH OF TX _____ FREQ/WEEK _____

HEPARIN: LOAD _____ U HEPARIN PUMP _____ ML/HR

STOP HEPARIN _____ MIN BEFORE END OF TX

DRY WT (kg) _____ OTHER WT _____ HEIGHT _____

DIABETIC YES NO (circle one) CODE STATUS (circle one) DNR FULL

Access Information

ACCESS TYPE (be specific) _____

LOCATION _____ DATE PLACED _____

IF CENTRAL LINE CATH, LIST HEPARIN DWELL VOLUMES _____ ART _____ VEN

NEEDLE GAUGE: 17G 16G 15G (circle one) BLOOD REVERSED: YES NO (circle one)

LIDOCAINE 1% SQ INJECTION: YES NO (circle one)

BLOOD FLOW RATE (max 500) _____ DIALYSATE FLOW _____

Medications Available at Nephrology, Inc.

EPOGEN _____ UNITS PER TX PER WEEK (circle one)

ARANESP _____ MCG PER TX PER WEEK (circle one)

HECTOROL _____ MCG PER TX PER WEEK (circle one)
(Zemplar not offered)

VENOFER _____ MG PER TX PER WEEK (circle one)

ALLERGIES: _____

Referring Facility Signature _____

Nephrology, Inc. Physician Signature _____



Release of Confidential Medical Information

The individual(s), whose signature(s) appear below, authorized the release of all requested medical and financial information to Nephrology, Inc., for the purpose of establishing medical care provided by the physicians and staff at Nephrology, Inc.

Patient Name (Printed)

Patient Signature

Date

Parent/Legal Guardian (Printed)

Parent/Legal Guardian Signature

Date



Understanding of Financial Responsibility

Nephrology, Inc. requires all co-payments and co-insurance be paid **prior** to your visit. Your total cost will be calculated from the information your home unit provides us - this includes all treatments, supplies, and medications. If Medicare is your primary insurance, you are responsible for 20% co-insurance. If any other insurance is primary, we require you to pay 100% of all charges. We will provide a payment worksheet to your home unit upon calculation of your treatment costs and verification of your insurance. Reimbursement of your co-insurance will be paid to you upon receipt of payment from your insurance provider.

Payment can be mailed to:

Nephrology, Inc.
250 East Day Road, Suite 300
Mishawaka, Indiana 46545

We also accept credit card payments by calling (574) 273-6787 extension 7309.

The individual, whose signature appears below, understands the payment process of Nephrology, Inc. and agrees to make payment as described above.

Patient Name (Printed)

Patient Signature

Date