

ESRD INITIAL SCREENING FORM

Date: _____ **Patient:** _____

ID: _____ **Phone:** _____

Nurse: _____ **Address:** _____

Risk: High ___ Med. ___ Low ___ **Dialysis Center:** _____

Race: _____ **Days and shift** _____

Access : _____ **Nephrologist:** _____

Allergies: _____

Risk Factors/Comorbids – Do you have any of the following:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Use BP meds	<input type="checkbox"/> Urinary problems
<input type="checkbox"/> Use Insulin	<input type="checkbox"/> CHF	<input type="checkbox"/> PVD	<input type="checkbox"/> Pain on urination
<input type="checkbox"/> Blindness	<input type="checkbox"/> Angina	<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Urinary urgency
<input type="checkbox"/> Smoke	<input type="checkbox"/> Stroke	<input type="checkbox"/> Numb. Legs/feet	<input type="checkbox"/> Urinary frequency
<input type="checkbox"/> Cancer	<input type="checkbox"/> High chol.	<input type="checkbox"/> Liver problems	<input type="checkbox"/> Urinary incontinence
<input type="checkbox"/> Anemia	<input type="checkbox"/> SOB	<input type="checkbox"/> Mental disorders	<input type="checkbox"/> Frequent UTIs
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Swelling hands/feet	<input type="checkbox"/> Transplant	<input type="checkbox"/> Frequent kidney stones
<input type="checkbox"/> Lupus	<input type="checkbox"/> MI	<input type="checkbox"/> Nephrectomy	

Do you have any of the following symptoms?

Nausea Poor appetite Fatigue Vomiting Insomnia

Do you have any health problems or symptoms we did not talk about? NO YES

Diabetes: If yes

Do you know your average glucose level? YES NO Value _____
Who prescribes diabetic control? _____
Do you check your feet daily? YES NO _____
Do you have sores or open areas on your feet now? NO YES _____
Do you have amputations? YES NO _____

How tall are you? _____

Do you check your weight daily? _____ Weight: _____

Do you check your blood pressure? YES NO Avg. BP: _____

Are you on a special diet? YES NO

Do you have a dialysis access? YES NO Access type, location & date placed _____

Do you have any transportation problems getting to appointments? YES NO _____

Have you been in the hosp. in the past 6 mths? NO YES – Reason _____

Have you gone to the ER in the past 6 mths? NO YES – Reason _____

Have you had any outpatient procedures in the past 6 mths? – Reason _____

Have you had any lab tests (blood draws) in the past 6 months? NO YES – Reason _____

Are you interested in a kidney transplant? _____

Referral made _____ Process started _____ Process completed _____

Listed at _____

Needs/Issues

When is the best time of day to contact you?

Comments

