



Members: ◇ Henry County Health Center  
◇ Southeast Iowa Regional Medical Center  
◇ Fort Madison Community Hospital  
◇ Jefferson County Health Center

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## Transient Cover Sheet

When inquiring about a transient patient, please include the following information. It is very important that we receive this information in a timely manner in order to review it and schedule a time for the patient. For any questions or concerns, please contact the appropriate facility listed below. We appreciate all copies are legible before faxing to the unit you are wanting to visit.

- Copies of Insurance Cards
- Patient Demographics
- 2728
- History and Physical
- Current Labs within last 30 days
- Current dialysis orders
- Hepatitis Status (surface antigen within last 30 days)
- TB test results (within last 30 days)
- Current Medication List
- Last 3 flowsheets
- Physician progress notes from past 3 months
- Advanced Directives
- Photo ID
- Dialysis Access Report
- Date of last Covid vaccination

### **Southeastern Renal Dialysis Units**

- ❖ *Mt. Pleasant, IA: Phone: 319-385-6720 Fax: 319-385-6726*
- ❖ *West Burlington, IA: Phone: 319-758-0691 Fax: 319-758-0392*
- ❖ *Keokuk, IA: Phone: 319-524-2105 Fax: 319-524-2188*
- ❖ *Ft. Madison, IA: Phone: 319-372-7996 Fax: 319-372-7830*
- ❖ *Fairfield, IA: Phone: 641-469-3313 Fax: 641-469-3350*



## **Dialysis Patient Financial Policy/Procedure**

Each patient requesting dialysis services at a Southeastern Renal Dialysis facility is required to forward all insurance information to the unit where dialysis will occur. This information will be reviewed by a member of the SRD team prior to the confirmation of treatments.

All charges for patients eligible for Medicare are submitted to Medicare for payment. If the patient has insurance, the business office will bill remaining charges/co-pays to the appropriate insurance company. If no additional insurance coverage is available, the patient will be responsible for the remaining balance. This amount will be determined and reviewed with the patient prior to the initiation of treatment.

### **Billing Information**

Name		
Phone		
Address		Zip Code
Date of Birth		
Emergency Contact Name		
Emergency Contact Phone #		
Emergency Contact Address		
Medicare ID #		Effective Date
Medicaid ID #		Effective Date
Other Insurance Policy #		
Other Insurance Name		
Insurance Address		

My signature below indicates that I understand and agree to comply with the above stated policy.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



**PATIENT SPECIFIC INFORMATION:  
(SYNOPSIS OF UNIQUE CHARACTERISTICS OF PATIENT'S TREATMENTS)**

Allergies: \_\_\_\_\_  
 Patient's trends and usual response to treatment \_\_\_\_\_  
 Inter dialytic wt. gains \_\_\_\_\_ # kg      B/P range: Pre \_\_\_\_\_ Intradialytic \_\_\_\_\_ Post \_\_\_\_\_  
 Usual BP support methods \_\_\_\_\_  
 \_\_\_\_\_  
 Unusual reactions or need \_\_\_\_\_  
 \_\_\_\_\_  
 Special needs or circumstances relative to transient visit \_\_\_\_\_  
 \_\_\_\_\_

**INTRADIALYTIC MONITORING: IF APPLICABLE, OTHERWISE NOTE "N/A"**

Special Labs \_\_\_\_\_ Blood glucose \_\_\_\_\_  
 Intradialytic treatments: Dressings \_\_\_\_\_ O2 \_\_\_\_\_ Other \_\_\_\_\_  
 EPO \_\_\_ Yes \_\_\_ No \_\_\_ Units \_\_\_\_\_ SQ \_\_\_\_\_ IV \_\_\_\_\_ x's/week  
 Calcijex \_\_\_ Yes \_\_\_ No \_\_\_\_\_ Mcg \_\_\_\_\_ X's/Week  
 Intradialytic meds: (i.e., Infed) \_\_\_\_\_  
 Mobility: \_\_\_\_\_ Ambulatory \_\_\_\_\_ Non-Ambulatory \_\_\_\_\_ Ambulatory with assist \_\_\_\_\_  
 Special Dietary Considerations \_\_\_\_\_  
 Intradialytic Nutrition Orders \_\_\_\_\_ Fluid Restriction \_\_\_\_\_

**ENCLOSURES: CHECK INDICATES INFORMATION SENT FROM HOME FACILITY**

_____ Standing Orders	_____ Advance Directive, if applicable
_____ Problem list (Last 6 months)	_____ Current H & P (within 1 year)
_____ Medication record (home and in-center)	_____ Hemo last 3 treatment records
_____ Most recent psycho-social evaluation	_____ Long-term care plan (current year)
_____ Patient care plan (most recent within 6 months)	_____ Most recent nutritional assessment
_____ Progress note (past 3 months to current)	_____ MD _____ RN _____ RD _____ MSW
_____ Diagnostic tests: _____ EKG _____ CXR (within 2 years)	_____ Laboratory profile (within last 30 days)
_____ HBsAg status _____ Positive _____ Negative	Date ____ / ____ / ____
_____ HbsAB status _____ Positive _____ Negative	Date ____ / ____ / ____      Vaccine series complete _____ Yes _____ No
_____ Insurance information, carrier name & address current copies (front & back) of the following:	
_____ Medicare card _____ Co-insurance card(s) _____ other (specify) _____	

**TRANSPLANT LIST INFORMATION (IF APPLICABLE) FOR SEASONAL PATIENTS ONLY**

\_\_\_\_\_ LRD \_\_\_\_\_ Cadaver  
 Transplant facility name and address \_\_\_\_\_  
 \_\_\_\_\_  
 Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

**SPECIAL INSTRUCTIONS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PATIENT IS NOT ACCEPTED UNTIL OFFICIAL NOTICE IS RECEIVED FROM RECEIVING UNIT.**

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 (Referring unit person who completes form)



**PATIENT SPECIFIC INFORMATION:  
(SYNOPSIS OF UNIQUE CHARACTERISTICS OF PATIENT'S TREATMENTS)**

Allergies: \_\_\_\_\_  
 Unusual reactions or needs: \_\_\_\_\_

Average B/P \_\_\_\_\_ Mobility: \_\_\_\_\_ Ambulatory \_\_\_\_\_ Non-Ambulatory \_\_\_\_\_ Ambulatory with assist  
 Special needs or circumstances relative to transient visit \_\_\_\_\_

Vascular access: \_\_\_\_\_ Yes \_\_\_\_\_ No Type: \_\_\_\_\_  
 Location: \_\_\_\_\_

**SPECIAL DIETARY CONSIDERATIONS**

Fluid Restriction \_\_\_\_\_

**ENCLOSURES: CHECK INDICATES INFORMATION SENT FROM HOME FACILITY**

Standing orders  Advance Directive, if applicable  
 Problem list (Last six months)  Current H&P (within 1 year)  
 Medication record (home and in-center)  PD last 3 clinic records  
 Most recent psycho-social evaluation  Long term care plan (current year)  
 Patient care plan (most recent within 6 months)  Most recent nutritional assessment  
 Copy of RX supply  Copy of self EPO training sheet  
 Progress note (past 3 months to current)  MD  RN  RD  MSW  
 Diagnostic tests  EKG  CXR (within 2 years)  Laboratory profile (within last 30 days)  
 HbsAg status  Positive  Negative Date \_\_\_/\_\_\_/\_\_\_ Vaccine Series Complete  yes  no  
 HBsAB status  Positive  Negative Date \_\_\_/\_\_\_/\_\_\_  
 Insurance information, carrier name & address current copies (front & back) of the following  
 Medicare card  Co-insurance card(s)  Other (specify) \_\_\_\_\_  
 Method I  Method II

**TRANSPLANT LIST INFORMATION (IF APPLICABLE) FOR SEASONAL PATIENTS ONLY**

LRD  Cadaver  
 Transplant facility name and address \_\_\_\_\_  
 \_\_\_\_\_  
 Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

**SPECIAL INSTRUCTIONS**

PATIENT IS NOT ACCEPTED UNTIL OFFICIAL NOTICE IS RECEIVED FROM RECEIVING UNIT.

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
 (Referring unit person who completes form)