



DIALYSIS CORPORATION OF AMERICA

DIALYSIS PATIENT REFERRAL FORM

Type of patient:

New

Transfer Hemodialysis

Transfer Peritoneal Dialysis

DCA of Lemoyne
27 Miller St, Ste A
Lemoyne, PA 17043
(717) 730-6011 ph
(717) 730-9086 fax

DCA of Mechanicsburg
120 South Filbert St
Mechanicsburg, PA 17055
(717) 790-6080 ph
(717) 790-6081 fax

DCA of Carlisle
101 Noble Blvd, Ste 103
Carlisle, PA 17013
(717) 258-3099 ph
(717) 258-3632 fax

DCA of Chambersburg
Park 5th Ave Professional Ctr
765 5th Ave, Ste A
Chambersburg, PA 17201
(717) 263-9300 ph
(717) 263-7879 fax

Name _____
Address _____

Date of Birth _____
Social Security # _____
Date of first dialysis _____

Telephone () _____

Referring Nephrologist _____

Diagnosis (Primary cause of ESRD) Prs Height =

Date of first anticipated treatment in outpatient unit _____

Emergency contact/ Next of Kin Information

Address and phone number if patient is to be discharged to a location other than address listed above

Name _____
Relationship to patient _____
Home Number _____
Work Number _____

Address _____

Agency Referrals (Home Health, Aging, etc)

Phone number _____

Transportation Plan: To/From Dialysis _____

Allergies:

THE FOLLOWING INFORMATION MUST BE FAXED TO THE FACILITY ALONG WITH THIS REFERRAL SHEET

New patients need all items listed in Column I

Transfer patients (Hemodialysis & Peritoneal) need all items listed in Columns I, II & III:

COLUMN I

- Hospital Admission Registration Sheet
- Insurance Cards (copy of front & back)
- Lab Reports (MUST include pre-dialysis labs)**
- Hepatitis B Antigen**
- Chest X-ray***
- EKG***
- Dialysis Access Info/Operative Report
- History and Physical***
- Last 3 Dialysis Treatment Sheets
- Hepatitis C Antibody**
- Medication List
- Was EPO administered pre-dialysis? Y N

COLUMN II

- Long & Short Term Care Plans
- Vaccination Record
- HCFA 2728
- Transplant Status/Living
- Method Selection Form*
- Most recent PET*, KT/V & URR
- Rolling 3 month average hemoglobin results

*- Needed for Peritoneal Dialysis transfers only

COLUMN III

Transfer Info:
Unit name: _____
Address: _____
Phone: _____

** - Must be within the last 30 days
*** - Must be within the last 12 months

extra LABS
- HBA1C + Lipid Profile

ALL info must be filled IN.