Renal Department **Dialysis Unit Patient Transfer**	*Patient Addressograph Label*

Patient Details	
Contact Number/s	
Next of Kin Details	
Name	
Relationship	
Address and Contact Number	

Clinical History			
Renal Diagnosis			
Past Medical History			
Is the patient diabetic?	Yes ☐	Details?	
	No ☐		
Known Allergies	Yes ☐	Details?	
	No ☐		
Resuscitation Status	For Resus ☐		
	DNACPR ☐	**ReSPECT Form MUST be Consultant Signed**	

Dialysis Treatment Details			
First Dialysis Treatment Date			
Dialysis Modality	HD ☐	HDF ☐	PD ☐
Dialysis Access Details	CVC ☐	AVF/G ☐	PD Catheter ☐
	If more than one access type is available, which is primarily used?		

Transplant Status			
Has the patient previously had a transplant?	Yes ☐		
	No ☐	Are they on the transplant list?	Yes ☐ No ☐

Social Circumstances

Home situation	Own home	☐	House	☐	Flat ☐	Bungalow	☐
	Supported living	☐	Details?				
	Nursing home	☐					
	Care home	☐					
	POC	☐	Details?				
Communication needs	Yes	☐	Details?				
	No	☐					
Mobility	Independent	☐					
	Walking aids	☐	Details?				
	Wheelchair	☐					
	Bed bound	☐					
Transport needs	Self-drive	☐					
	Car	☐					
	Wheelchair	☐					
	Ambulance	☐					

Infection, Prevention and Control			
Serology tested	Yes	☐	Details?
CPE screening result	Positive	☐	Details?
	Negative	☐	
MRSA screening result	Positive	☐	Details?
	Negative	☐	
Does the patient require isolation nursing	Yes	☐	Details?
	No	☐	

Documents for transfer	
ReSPECT form	☐
Virology checklist	☐
Current drug list	☐
IV drugs administration chart	☐
HD checklist	☐
CVC monitoring chart	☐
Purpose T and MUST	☐
Confirmation of dietician referral	☐

Name		Signature	
Designation		Date	