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	