

Toronto Rehabilitation Institute Dialysis Service – Dialysis Application Form

*****On completion please Fax to TRI dialysis co-ordinator at 416 977 8719 *****

Patient Name:	Referring Physician:
Address:	Physician contact number:
DOB:	Medical record number:
	Gender: Male Female

Referral to: CCC program (long term) Geriatric Rehabilitation Program

❖ ESRD secondary to:

❖ Date of 1st RRT and dialysis history (previous Tx, PD, HD etc)

❖ Acute deterioration leading to need for Rehab due to (rehab only):

Comorbid conditions:

1. Cardiac disease Y / N details:
2. Hypertension Y / N details:
3. Diabetes Y / N details:
4. Vascular disease Y / N details:
(includes Periph. vasc or Cerebrovasc):
5. Skin breakdown Y / N details:
6. Other comorbidity (with details)

Issues for TRI dialysis team to follow on transfer:

- Problems on dialysis? Y / N details:
 Blood work issues of concern Y / N details:
 Medication issues of concern Y / N details:
 Vasc access issues of concern Y / N details:
 Other issues for follow up Y / N details:
- | | | | | |
|---------------------------|-----------|-----------|-----------|---------|
| Hep B Status (circle one) | HbsAg -ve | HbsAg +ve | HbsAb +ve | unknown |
| HIV status (circle one) | negative | positive | unknown | |

1/7/10

Date (day/month/yr) _____ / _____ / _____

(Once completed, the referral can be faxed to 416-597-7067 in addition to the number listed above.)

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Addressograph:

Checklist of documents enclosed:

- _____ 3 (most recent) dialysis run sheets
- _____ Current medication list
- _____ MRSA, VRE results
- _____ *Lab flow sheet (if available) OR recent bloodwork.*
- _____ *Other pertinent medical information or recent medical summaries (if available)*

Completed by (please print CLEARLY) _____

RN MD Other