NORTHWEST Kidney Centers

Dear New Patient

Welcome to Northwest Kidney Centers! We were the first outpatient dialysis provider in the world. Northwest Kidney Centers is private, non-profit, and committed to being a model in our field in improving the health and survival of people with kidney disease.

Starting dialysis is hard. Our job is to make it easier for you, by educating you and giving you information about how to live well on dialysis.

At Northwest Kidney Centers, we believe in education. Over the next several months, your care team will be spending a lot of time with you to help you understand:

- What you can do to improve your health and survival
- Your kidney disease
- How dialysis works and how it affects your body
- Other treatments—home dialysis and transplant
- What to do in an emergency

If you have questions, ask! Don't be afraid to say if you don't understand something—there is a lot to learn.

Dialysis is a lifesaving treatment. Let's work together to make sure you understand how to make **your life** as long and as healthy as possible.

Let's get started!

Your Northwest Kidney Centers' Care Team

Your Rights as a Dialysis Patient

Your rights as a patient in a Medicare-certified facility	What this means for you:
Respect, dignity, and recognition of his/her individuality and personal needs, and sensitivity to his/her psychological needs and ability to cope with kidney disease.	Staff should always treat you with courtesy and take into consideration your special needs and situation.
Receive all information in a way that he/she can understand.	We try to give clear explanations and to make written materials easy to understand. Always ask if you don't understand. If you need an interpreter, we will provide one at no cost to you.
Privacy and confidentiality in all aspects of treatment.	Private discussions with staff can be scheduled in a room outside of the treatment area. We will use screens, blankets, curtains, etc. to avoid exposing private body parts in the treatment area, but your face and access site must always be visible during dialysis.
Privacy and confidentiality in personal medical records.	We protect the security of your medical records and maintain privacy under HIPAA rules.
Be informed about and participate, if desired, in all aspects of his/her care, and be informed of the right to refuse treatment, to discontinue treatment, and to refuse to participate in experimental research.	You can choose to take part in your care; for example, participating in your plan of care conference, putting in your own needles, etc. You have the right not take part in your care if you choose. We will inform you of any changes in your dialysis treatment prescription and the reasons for those changes. You have the right to refuse any treatment, and to refuse to take part in any experimental research.

NORTHWEST Kidney Centers

Your rights as a patient in a Medicare-certified facility	What this means for you:
Be informed about his/her right to execute advance directives, and the facility's policy regarding advance directives.	You have the right to have an advance directive (a document in which you direct your healthcare decisions if you are unable to speak for yourself). Your dialysis social worker will provide more information about advance directives.
Be informed about all treatment modalities and settings, including but not limited to, transplantation, home dialysis (home hemodialysis, intermittent peritoneal dialysis, continuous ambulatory peritoneal dialysis, continuous cycling peritoneal dialysis), and in-facility hemodialysis. The patient has the right to receive resource information for dialysis modalities not offered by the facility, including information about alternative scheduling options for working patients.	We will provide information on types of dialysis and kidney transplant. Northwest Kidney Centers offers all types of dialysis; hemodialysis in a center and at home, peritoneal dialysis (CAPD and APD). Note: Home dialysis is not available to patients with Acute Kidney Injury (AKI). If you work or go to school, we will do all we can to accommodate your schedule.
Be informed of facility policies regarding patient care, including, but not limited to, isolation of patients.	To protect other patients from disease, patients with certain kinds of infections, such as hepatitis B, must dialyze in special areas or locations. If you should have this kind of infection, you will be informed of changes of location and schedule.
Be informed by the physician, nurse practitioner, clinical nurse specialist, or physician's assistant treating the patient for kidney disease of his/her own medical status as documented in the patient's medical record, unless the medical record contains a documented contraindication.	Your doctor (or his/her nurse practitioner or physician's assistant) must provide you with information about your medical condition.

Your rights as a patient in a Medicare-certified facility	What this means for you:
Be informed of the services available in the facility and charges for services not covered by your insurance.	You will get advance notice of any charges for services not covered by your insurance.
Receive the necessary services outlined in the patient plan of care described in the Conditions for Coverage, section 494.90.	Your care team, which includes you, makes a personalized plan for your care, and you have a right to receive the services in that plan.
Be informed of the rules and expectations of the facility regarding patient conduct and responsibilities.	Your care team will give you a copy of Northwest Kidney Centers' Patient Responsibilities which covers our rules and expectations.
Be informed of the facility's internal grievance process.	You can make a complaint about your care to Northwest Kidney Centers. We have a process for handling complaints to make sure that your concerns addressed. The policy is posted in your center, and we will give you more information on the process.
Be informed of external grievance mechanisms and processes including how to contact the ESRD Network and the State survey agency.	You can make a complaint about your care to the Northwest Renal Network or to the Washington State Department of Health survey agency. The contact information for both is posted in your center.
Be informed that he|she may file internal or external grievances, personally, anonymously or through a representative of patient's choosing without reprisal or denial of services.	You can make complaints anonymously or have another person make the complaint for you. You may continue to receive care at NKC and we will treat you with respect and in a professional manner.

Your rights as a patient in a Medicare-certified facility	What this means for you:
Be informed of the facility's policies for transfer, routine or involuntary discharge, and discontinuation of services to patients.	We have policies about transfers to another center, whether by your choice or because we are discharging you. The policy is posted in your unit, and we will provide an explanation of those policies.
Receive written notice 30 days in advance of an involuntary discharge, after the facility follows the involuntary discharge procedures described in the Conditions for Coverage, section 494.180(f)(4). In the case of immediate threats to the health and safety of others, an abbreviated discharge procedure may be allowed.	We must give you 30 days written notice before discharging you, unless there is an immediate threat to the health or safety of others.

At Northwest Kidney Centers, we take your rights seriously. We are focused on your health, quality of life, and the success of your kidney dialysis treatment.

If you are concerned about your health or general well-being while at an NKC location, please notify a staff person and/or manager as soon as possible.

Patient Responsibilities

Treat others (staff, patients, visitors) with courtesy and respect

- We provide care to patients with a wide range of needs. You can show respect to your fellow patients by:
  - Limiting scents that could trigger allergic reactions in others
  - Using earbuds or headphones
  - Keeping your voice down
  - Avoiding abusive/threatening talk or behavior
  - Not discussing other patients' medical information
  - Refraining from taking photographs, or making video/audio recordings while on our premises

Follow the law when at dialysis clinic

- Help keep our centers safe by:
  - Not bringing guns, knives, or weapons to dialysis
  - Not engaging in illegal activities such as using or selling drugs, or consuming alcohol on the premises
  - Not damaging or stealing equipment and property belonging to NKC or others

Maintain professional relationships with staff

- We promote equal treatment of patients by all staff. You help us do this by:
  - Refraining from giving gifts to staff
  - Not exchanging money with staff for any purpose
  - Avoiding contact with staff through social media, email or phone/texting
  - Not dating staff or engaging in social activities with them

Take responsibility for your care

- You are the most important member of your care team! Keep yourself healthy by:
  - Attending dialysis as prescribed by your nephrologist
  - Taking your medications as prescribed
  - Following fluid and diet restrictions
  - Keeping medical appointments
  - Following emergency procedures in the center and at home, when needed
  - Knowing phone numbers to call for help—your center, your care team, your doctors, transportation

Follow your hemodialysis schedule

- To ensure everyone's needs are met:
  - Arrive 30 minutes before your scheduled "on" time
  - Call as soon as you know you will be late or miss a scheduled treatment
    - We may need to shorten your treatment time if you arrive late
  - Ask for a make-up treatment if you miss your regular treatment
  - Wait in the lobby for staff to call you into the treatment area as chair assignments may change
  - We may need to change your schedule for safety or operational reasons—we will give you as much notice as possible
  - All NKC staff complete extensive training to provide care for all patients
    - We are unable to exclude staff from being assigned to you
    - You have the right to reschedule treatment; speak to the clinic manager if you have care concerns

Remain safe at dialysis

- These guidelines will help ensure a safe and comfortable dialysis treatment:
  - Consider bringing your own blanket, sheet, or pillow (use washable cover)
    - Take items home after each treatment and wash often, using bleach if there are bloodstains
  - Bring only battery-operated electronic devices and ensure they are charged
  - Keep personal items secure as NKC is not financially responsible for them
  - Wear shoes when walking in the center
  - Prepare for your treatment—
    - Get the ice/water you will want
    - Weigh yourself and make note of it
    - Wash your access arm
  - While on dialysis—
    - Keep your face and access visible
    - Only allow staff to adjust your machine
    - Allow blood pressure checks
    - Use wheelchair to go to restroom, or as requested by staff, to prevent falls
  - Hold puncture sites after dialysis

Visitors

- Visitors are allowed except in times of increased infection or safety risk and follow the same guidelines for respect that are expected of patients
  - We may limit the number of visitors or length of visit time depending on space, in the unit, activity, or other situations
  - During a medical emergency, visitors may be instructed by staff to leave the treatment area
  - Children should not accompany their parents to dialysis routinely
    - For infection control, children under age 10 must remain in the waiting area and under the care of an adult
    - Children ages 10 -15 may come into the treatment area under the supervision of an adult other than the patient
  - Please check with your unit for current visitor guidelines and review the Visitor Infection Prevention handout

Let us know when...

- Your name, address, phone, emergency contacts or health insurance has changed
- You want to speak to your social worker, dietitian, nurse, patient finance coordinator, or unit manager
- You wish to speak to staff privately

CKD-PE-2 11/11/2022

Transportation for PD Patients

What are my options?

If you need help with transportation to dialysis, there are a two options:

- Paratransit Programs
  - Provided by King, Pierce and Snohomish Counties
  - No insurance or income limitations
- Hopelink/DSHS provided through Medicaid (also known as Apple Health)
  - Income based; available only to people with Medicaid
- Your Social Worker can help you apply

Transportation Line

- Once approved for rides with your county paratransit or DSHS provider, you can:
  - Call and book your own rides
  - Use the NKC transportation line to help arrange your rides for dialysis
- Plan ahead when booking rides—
  - Paratransit rides must be made at least 1 day in advance, not counting holidays
- Tell the call taker if anyone is riding with you or if you use any special equipment like a walker or wheelchair
- Have your appointment time, length and dialysis clinic name ready when you call

When should you call?

- If you need rides to a PD clinic appointment
- If the appointment time or length changes
- If you need to cancel your ride
- If your ride does not come or arrives late

Transportation Line Numbers

- Northwest Kidney Centers ride line
  - (206) 292-2704; toll free (866) 989-4932
  - Requests may be made Monday through Friday between 8:00 AM - 4:00 PM
  - Requests made after 4:00 PM will be handled the next business day
- King County Metro ACCESS
  - (206) 205-5000
- Pierce County Transit Shuttle
  - (253) 581-8000
- Snohomish County DART (Dial-A-Ride)
  - (425) 347-5912
- Hopelink/DSHS
  - King County call (800) 923-7433
  - Pierce County call (855) 553-0355
  - Snohomish County call (855) 766-7433

Getting Ready for PD Checklist

Week 1

- ☐ Liquid soap in a pump (no refills)
- ☐ Paper towels
- ☐ Gentamicin cream
- ☐ Germ-killing cleaner (spray or wipes)
- ☐ Read training manual sections 1 and 2
- ☐ *Daily exit site care (may start week 2)

Week 2

- ☐ Read training manual sections 3 and 4
- ☐ Exit site care – daily (from now on)
- ☐ Prepare treatment area
  - ☐ Handwashing sink nearby
  - ☐ Good lighting
  - ☐ Quiet, low traffic, low airflow (or airflow can be turned off)
  - ☐ Telephone access
  - ☐ Table/worksurface
  - ☐ Quiet, away from distractions
  - ☐ Pets can be kept out of area
  - ☐ Cycler (APD) requires: power outlet
- ☐ Prepare storage are for supplies
  - ☐ 4’x7’ area for boxes
  - ☐ No shelves
  - ☐ Couple smaller areas okay

Week 3

- ☐ Read remainder of training manual
- ☐ Optional: document holder
- ☐ Optional: drain bag holder
- ☐ Supply area ready
- ☐ Treatment area ready

NORTHWEST Kidney Centers

Dear New Patient,

Northwest Kidney Centers has a Patient Finance Department located in SeaTac at our Burien Pavillion. You have been assigned a Financial Case Manager to work with you to make sure you have the funding you need to cover dialysis services.

We know you may have a lot of questions regarding your dialysis funding. In order for your Financial Case Manager to be able to best answer your questions, we need you to complete and sign the following forms in your packet:

- Read the Patient Account Agreement, sign and date where indicated. There is also a copy of this form for you to *keep a copy for your records*.
- Fully complete the Patient Registration Form
- Sign Part I of the Appointment of Representative form for Social Security where it states "Signature (Claimant)"
- Sign the Department of Social and Health Services (DSHS) Authorization form in the box marked "Authorized By (Client Signature)"
- Provide a copy of your driver's license and insurance card(s). Free copies can be made at the dialysis center.
- If you were **not** born in the United States, provide a copy of your green card, passport or Visa. Free copies can be made at the dialysis center.

Once your Financial Case Manager receives the above information, they will call you to review your funding options and answer any questions you may have. Meanwhile, if you wish to speak with someone about dialysis coverage, call (206) 292-2771, press 0 and ask to speak to your Financial Case Manager.

Thank you very much,

Patient Finance Department
Northwest Kidney Centers

NORTHWEST Kidney Centers

Patient Account Agreement

By signing this form

I agree to pay for all services provided, arranged or furnished by Northwest Kidney Centers (NKC) according to the current rates and terms of the facility.

Financial Responsibility and Sources of Payment

- I agree to apply for and use all available funding sources that are needed to pay for NKC charges; NKC will provide a Financial Case Manager to assist with applications.
- I agree to provide NKC with any financial and personal information needed to obtain and maintain coverage from funding sources.
- I agree to pay any applicable charges not paid by funding sources.
- I agree to notifying NKC about any changes in funding sources, including:
  - Loss of or change in insurance coverage
  - Eligibility for new coverage
  - Enrollment in Medicare or Medicaid

Assignment of Benefits

- I agree to assign to NKC all insurance benefits payable toward NKC charges.
- I agree to forward NKC any insurance payments received that are intended to pay for NKC charges.

Authorization to Release Information

- I authorize NKC to release any needed information to funding sources in order to apply for funding or to determine eligibility and/or benefits payable.

I have read, or someone has read to me, the **Patient Account Agreement** (CKD-PE-42, 1/01/2023). I have received a copy and I understand the information.

Signed:

_____
Patient Name (Print)

x _____ _____
☐ Patient ☐ Legal Guardian/Representative ☐ Power of Attorney Date

_____
Witness Name (Print)

x _____ _____
Witness Signature Date

x _____ _____
☐ Translator ☐ Reader Date

Patient Name **NKC #**

NORTHWEST Kidney Centers

Patient Registration Form

Patient Information

Legal name: _____

Last First Middle / Initial

Date of birth: _____ Sex assigned at birth: ☐ Male ☐ Female

Place of birth (City, State, Country): _____

How do you currently describe yourself?

☐ Male ☐ Female ☐ Transgender male ☐ Transgender female ☐ None of these

Maiden name: _____ Social Security Number: _____

Home address: _____

City: _____ State: _____ Zip code: _____ Primary phone: _____

Email address: _____ Secondary phone: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally separated

Spouse name: _____ Maiden name: _____

Spouse date of birth: _____ Spouse Social Security: _____

Do you understand health literature in English? ☐ Yes ☐ No

Do you need a different way other than written documents to learn about your health? ☐ Yes ☐ No

Is an interpreter needed? ☐ Yes ☐ No If yes, language: _____

Is transportation needed? ☐ Yes ☐ No

Are you hearing impaired? ☐ Yes ☐ No Are you visually impaired? ☐ Yes ☐ No

Do you have power of attorney? ☐ Yes ☐ No ☐ Not sure *If yes, please provide a copy.*

Do you have a living will or Physician Order for Life Sustaining Treatment (POLST)?

☐ Yes ☐ No ☐ Not sure

Do you have a caregiver who assists with your daily care? ☐ Yes ☐ No

Do you have a caregiver who can help you with home dialysis or after a kidney transplant? ☐ Yes ☐ No

If you have a caregiver, do they live with you? ☐ Yes ☐ No

NORTHWEST Kidney Centers

Patient Registration Form

Emergency Contacts

1. Name: _____ Relationship: _____

Primary phone: _____ Secondary phone: _____

2. Name: _____ Relationship: _____

Primary phone: _____ Secondary phone: _____

3. Name: _____ Relationship: _____

Primary phone: _____ Secondary phone: _____

Employment

Current Employment:

☐ Full time ☐ Part time ☐ Unemployed ☐ Student ☐ Homemaker
☐ Medical leave ☐ Retired due to age/preference ☐ Retired (disability) ☐ Volunteer

Employment 6 months ago:

☐ Full time ☐ Part time ☐ Unemployed ☐ Student ☐ Homemaker
☐ Medical leave ☐ Retired due to age/preference ☐ Retired (disability) ☐ Volunteer

Employer name: _____ Phone number: _____

Employer address: _____

Number of employees: ☐ Over 20 ☐ Over 100

If you are retired, please provide the reason and date of retirement:

_____

Are you on medical leave? ☐ Yes ☐ No

If yes, start date of medical leave: _____ end date of medical leave: _____

Are you on COBRA or elected COBRA coverage? ☐ Yes ☐ No

If yes, start date of coverage: _____ end date of coverage: _____

Patient Registration Form

Have you served in the military? ☐ Yes ☐ No

If yes, dates of service: from year _____ to year _____

Citizenship, Race & Ethnicity

Are you a U.S. citizen? ☐ Yes ☐ No

If you were not born in the United States, please provide a copy of your passport or Visa.

Are you an undocumented resident? ☐ Yes ☐ No

Are you a resident of Washington State? ☐ Yes ☐ No

Please self-identify your race and ethnicity. For American Indian/Alaskan Native responders, please indicate tribal affiliation(s).

Ethnicity: Country of Origin: _____

☐ Non-Hispanic or Non-Latino
☐ Hispanic or Latino

Race (check all that apply):

☐ American Indian/Alaska Native Name of Enrolled/Principal Tribe: _____

☐ Asian
- ☐ Asian Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ Filipino ☐ Vietnamese
- ☐ Guamanian or Chamorro ☐ Other Asian

☐ Black or African American

☐ Middle Eastern or North Africa

☐ Native Hawaiian or Pacific Islander
- ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Samoan

☐ White

☐ Multiracial (check all that apply)

☐ Other if unable to identify with any of these races

NORTHWEST Kidney Centers

Patient Registration Form

Medical History

Are you on the list for a kidney transplant or currently working with a transplant program?

☐ Yes ☐ No ☐ Unknown

If yes, hospital name: _____

Have you ever had a kidney transplant? ☐ Yes ☐ No

If yes, hospital name: _____ City/State: _____

Do you understand your options when it comes to kidney transplant? ☐ Yes ☐ No

Do you understand your options for a living donor transplant? ☐ Yes ☐ No

Have you been on dialysis before? ☐ Yes ☐ No

If yes, dates of dialysis treatment: from month/year _____ to month/year _____

City/State: _____

Do you understand what the options are for performing dialysis at home? ☐ Yes ☐ No

Insurance Information

Please complete the information and provide a copy of your insurance card(s).

Medicare number: _____ Effective date A/B: _____

Do you need help with insurance premiums, including COBRA? ☐ Yes ☐ No

Do you need help with prescription costs? ☐ Yes ☐ No

Insurance name: _____

Group number: _____ Policy number: _____

Subscriber name: _____ Effective date: _____

Have you applied for Medicaid from the Department of Social and Health Services (DSHS)?

☐ Yes ☐ No ☐ Not sure

Do you have prescription coverage? ☐ Yes ☐ No

NORTHWEST Kidney Centers

Patient Registration Form

Do you expect a change in your or your spouse's employment any time soon? ☐ Yes ☐ No

If yes, what change and how soon? _____

Number of years you have worked and paid Social Security taxes? _____

Number of years your spouse worked and paid Social Security taxes? _____

Are you currently receiving Social Security income? ☐ Yes ☐ No

Please complete if you are receiving insurance benefits through someone other than yourself.

Name: _____ Relationship: _____

Current Employment:

☐ Full time ☐ Part time ☐ Unemployed ☐ Student ☐ Homemaker
☐ Medical leave ☐ Retired due to age/preference ☐ Retired (disability) ☐ Volunteer

Employer name: _____ Phone number: _____

Employer address: _____

Number of employees: ☐ Over 20 ☐ Over 100

If you are retired, please provide the reason and date of retirement:

_____

FOR FACILITY USE ONLY

Staff Name: _____ Date: _____

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1.To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2.To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3.To comply with Federal laws requiring the disclosure of the information from our records; and,
4.To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov**. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form*).

TO: Social Security Administration

***My Full Name**	***My Date of Birth (MM/DD/YYYY)**	***My Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:** Northwest Kidney Centers/Patient Finance Dept.

***ADDRESS OF PERSON OR ORGANIZATION:** 12901 20th Ave S, SeaTac, WA 98168-5159

***I want this information released because:** It is required by the state Medicaid Program

We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**

Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date_____ to date_____

   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☑ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

   Medicare award letter or denial letter, Social Security Award letters.

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

Authorized Representative

An Authorized Representative is someone you designate to represent you when you apply for or receive benefits with the Department of Social and Health Services (DSHS) or Health Care Authority (HCA). This individual or organization is authorized to act on your behalf for eligibility purposes. Having an authorized representative is optional; DSHS or HCA cannot withhold benefits if you do not sign this form.

Client Information

NAME	ACES CLIENT ID NUMBER

Authorized Representative Information

NAME	ORGANIZATION AND DEPARTMENT (IF APPLICABLE)	PHONE NUMBER (AREA CODE)
	Northwest Kidney Centers	(206) 292-2771

MAILING ADDRESS	CITY	STATE	ZIP CODE
12901 20th Ave S	SeaTac	WA	98168-5159

Program and Duration Information

Which program(s) do you want your authorized representative to act on in your behalf? Check all that apply.

☐ Cash Benefits ☐ Basic Food Benefits ☒ Health Care Coverage ☐ Long-term Care Coverage

How long do you want your authorized representative to act on your behalf?

☐ 90 days ☒ End of certification period (usually one year)

You may withdraw or revoke your request for an authorized representative at any time, verbally or in writing, without any impact on benefits.

Correspondence Information

Please check the level of information or benefits you want your authorized representative to receive.

	FOR DEPARTMENT USE ONLY Rep Type
For Cash, Basic Food, Health Care Coverage or Long-Term Care (check only one of the four boxes below)	
☐ Discuss my eligibility for benefits with a DSHS/HCA representative and not receive letters.	NC
☐ Receive DSHS/HCA letters and discuss my eligibility for benefits.	NO
☒ Receive DSHS/HCA letters, renewal forms and discuss my eligibility for benefits.	AD
☐ Receive DSHS/HCA letters, renewal forms, payments, ProviderOne cards and discuss my eligibility for benefits	NA
For Health Care Coverage Only (check either box below if applicable)	
☐ Hospital representative – receive letters and discuss my eligibility for benefits.	HO
☐ Sponsor paying premiums. Sponsors name and address sent to Office of Financial Recovery	SB

Client Authorization

AUTHORIZED BY (CLIENT SIGNATURE) DATE SIGNED	PRINT NAME	PHONE NUMBER (AREA CODE)

NOTE: HIPAA restrictions prevent us from discussing the client's individual health information with the authorized representative unless the representative has power of attorney for the client or the client has signed a DSHS 14-012, Consent form. This includes disclosure of mental health information, HIV/AIDS and STD test results, or treatment and chemical dependency services.

FOR DEPARTMENT USE ONLY
INSTRUCTIONS

Rep Type – ACES does not limit the Rep Type selections to the codes listed above. If a program requires a Rep Type not listed above or if one of the above codes is selected but is not appropriate for the situation (such as for a group home, protective payee, etc.) enter the appropriate program specific Rep Type on the AREP screen.

Barcode label

14532

Patient History Form

Please provide the information below by performing a chart review of the patient's medical history available in EMR Document Management.

Send this form to Clinical Informatics at Burien Pavilion via interoffice mail with the signed 2728 Form.

Patient Name: _____
Last First Middle / Initial

Did patient start chronic dialysis prior to admission to Northwest Kidney Centers? ☐ Yes ☐ No If yes, date: _____

Location: _____

Prior to ESRD Therapy

Did patient receive EPO or equivalent? ☐ Yes ☐ No ☐ Unknown If yes, ☐ <6 months ☐ 6-12 months ☐ >12 months

Was patient under care of a nephrologist? ☐ Yes ☐ No ☐ Unknown If yes, ☐ <6 months ☐ 6-12 months ☐ >12 months

Was patient under care of a kidney dietitian? ☐ Yes ☐ No ☐ Unknown If yes, ☐ <6 months ☐ 6-12 months ☐ >12 months

Was patient diagnosed with AKI in the last year? ☐ Yes ☐ No ☐ Unknown If yes, was dialysis required? ☐ Yes ☐ No

Does patient indicate they received & understood the option of not starting dialysis at all? ☐ Yes ☐ No

Treatment Options

Does the patient understand kidney transplant options? ☐ Yes ☐ No

If patient is not informed (or does not understand), check all that apply:

☐ Patient found information overwhelming
☐ Cognitive impairment
☐ Patient has an absolute contraindication
☐ Patient declined information
☐ Patient has not been assessed at this time
☐ Other

Has the patient been connected to a transplant center with a referral? ☐ Yes ☐ No

If yes, date of referral: _____ Name of transplant center: _____

Does the patient understand home dialysis treatment options? ☐ Yes ☐ No

If not informed (or does not understand), check all that apply:

☐ Patient found information overwhelming
☐ Cognitive impairment
☐ Patient has an absolute contraindication
☐ Patient declined information
☐ Patient has not been assessed at this time
☐ Other

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0046
Expires: 11/30/2026

END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT

Medicare entitlement and/or patient registration

A. Complete for all ESRD patients.

Select one: ◯ **Initial** ◯ **Re-entitlement** ◯ **Supplemental**

1. Last name | First name | Middle initial

2. Medicare Number (if available) | 3. Social Security Number | 4. Date of birth (mm/dd/yyyy)

5. Patient mailing address (include city, state and ZIP Code)

6. Phone number (including area code) | 7. Alternate phone number (including area code)

8. Sex assigned at birth, on your original birth certificate
◯ Male ◯ Female

9. How do you currently describe yourself
◯ Male ◯ Female ◯ Transgender male ◯ Transgender female ◯ None of these

10. Ethnicity*
◯ Not Hispanic or Latino ◯ Hispanic or Latino

11. Country/area of origin or ancestry

12. Race* ☐ Multiracial (check all that apply)

☐ American Indian/Alaska Native

☐ Asian
- ☐ Asian Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ Filipino ☐ Vietnamese ☐ Guamanian or Chamorro ☐ Other Asian

☐ Black or African American

☐ Middle Eastern or North Africa

☐ Native Hawaiian or Pacific Islander
- ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Samoan

☐ White

☐ Other if unable to identify with any of these six race categories

Print name of enrolled/principal tribe: _____

13. Is patient applying for ESRD Medicare coverage? ..... ◯ Yes ◯ No

14. Current medical coverage (check all that apply)
☐ Employer group health insurance ☐ Medicare ☐ Medicaid ☐ Veterans Administration ☐ Medicare Advantage ☐ Other
☐ None

15. Height: inches _____ **OR** centimeters _____

16. Dry weight: pounds _____ **OR** kilograms _____

17. Primary cause of renal failure (use code at end of form)

*Go to instructions

The collection of this information is authorized by Section 226A of the Social Security Act. The information provided will be used to determine if an individual is entitled to Medicare under the End Stage Renal Disease provisions of the law. The information will be maintained in system No. 09-700520, "End Stage Renal Disease Program Management and Medical Information System (ESRD PMMIS)", published in the Federal Register, Vol. 67, No. 116, June 17, 2002, pages 41244-41250 or as updated and republished. Collection of your Social Security Number is authorized by Executive Order 9397.

Furnishing the information on this form is voluntary, but failure to do so may result in denial of Medicare benefits. Information from the ESRD PMMIS may be given to a congressional office in response to an inquiry from the congressional office made at the request of the individual; an individual or organization for research, demonstration, evaluation, or epidemiologic project related to the prevention of disease or disability, or the restoration or maintenance of health.

18. Occupation status (6 months prior and current status)

Prior	Current		Prior	Current	
○	○	Unemployed	○	○	Retired (disability)
○	○	Employed full time	○	○	Medical leave of absence
○	○	Employed part time	○	○	Student
○	○	Homemaker	○	○	Volunteer
○	○	Retired due to age/preference			

19. Co-morbid conditions (check all that apply currently and/or during last 10 years)

- ☐ a. Congestive heart failure
- ☐ b. Atherosclerotic heart disease ASHD
- ☐ c. Other cardiac disease
- ☐ d. Cerebrovascular disease, CVA, TIA*
- ☐ e. Peripheral vascular disease*
- ☐ f. History of hypertension
- ☐ g. Amputation
- ☐ h. Diabetes
  - ☐ Currently on insulin
  - ☐ Currently use other injectable
  - ☐ On oral medications
  - ☐ Without medications
- ☐ i. Diabetic retinopathy
- ☐ j. Chronic obstructive pulmonary disease
- ☐ k. Tobacco use (current smoker)
- ☐ l. Malignant neoplasm, cancer
- ☐ m. Toxic nephropathy
- ☐ n. Alcohol dependence
- ☐ o. Drug dependence*
- ☐ p. Inability to ambulate*
- ☐ q. Inability to transfer*
- ☐ r. Needs assistance with daily activities*
- ☐ s. Alternate housing arrangement:
  - ☐ Assisted living
  - ☐ Nursing home
  - ☐ Other institution
- ☐ t. Non-renal congenital abnormality
- ☐ u. None (no comorbidities)
- ☐ v. Protein calorie malnutrition
- ☐ w. Morbid obesity
- ☐ x. Endocrine metabolic disorders
- ☐ y. Intestinal obstruction/perforation
- ☐ z. Chronic pancreatitis
- ☐ aa. Inflammatory bowel disease
- ☐ bb. Bone/joint/muscle infections/ necrosis
- ☐ cc. Dementia
- ☐ dd. Major depressive disorder
- ☐ ee. Myasthenia gravis
- ☐ ff. Guillain-Barre syndrome
- ☐ gg. Inflammatory neuropathy
- ☐ hh. Parkinson's disease
- ☐ ii. Huntington's disease
- ☐ jj. Seizure disorders and convulsions
- ☐ kk. Interstitial lung disease
- ☐ ll. Partial-thickness dermis wounds
- ☐ mm. Complications of specified implanted device or graft
- ☐ nn. Artificial openings for feeding or elimination

Consider for Pediatric Patients:

- ☐ oo. Chronic lung disease (including dependency on CPAP and ventilators)
- ☐ pp. Vision impairment
- ☐ qq. Feeding tube dependence
- ☐ rr. Failure to thrive/feeding disorders
- ☐ ss. Congenital anomalies requiring subspecialty intervention (cardiac, orthopedic, colorectal)
- ☐ tt. Congenital bladder/urinary tract anomalies
- ☐ uu. Non-kidney solid organ
- ☐ vv. Stem cell transplant
- ☐ ww. Neurocognitive impairment
- ☐ xx. Global developmental delay
- ☐ yy. Cerebral palsy
- ☐ zz. Seizure disorder

20. Prior to ESRD therapy:

a. Did patient receive exogenous erythropoetin or equivalent? ○ Yes ○ No ○ Unknown
If yes, answer: ○ <6 months ○ 6-12 months ○ >12 months

b. Was patient under routine care of a nephrologist? ○ Yes ○ No ○ Unknown
If yes, answer: ○ <6 months ○ 6-12 months ○ >12 months

c. Was patient under routine care of kidney dietitian? ○ Yes ○ No ○ Unknown
If yes, answer: ○ <6 months ○ 6-12 months ○ >12 months

d. What access was used on first outpatient dialysis:
○ AVF ○ Graft ○ PD catheter ○ Central venous catheter ○ Other

If not AVF, then: Is maturing AVF present? ○ Yes ○ No
Is graft present? ○ Yes ○ No
Was one lumen of the central venous catheter used and one needle placed in a AVF or graft? ○ Yes ○ No
Is PD catheter present? ○ Yes ○ No

e. Was patient diagnosed with an acute kidney injury in the last 12 months? ○ Yes ○ No ○ Unknown
If yes, was dialysis required? ○ Yes ○ No

f. Does the patient indicate they received and understood options for a home dialysis modality? ○ Yes ○ No

g. Does the patient indicate they received and understood options for a kidney transplant? ○ Yes ○ No
For living donor transplant ○ Yes ○ No

h. Does the patient indicate they received and understood the option of not starting dialysis at all, also called active medical management without dialysis? ○ Yes ○ No

*Go to instructions

21. Laboratory values within 45 days prior to the most recent ESRD episode. If not available within 30 days of admission to the dialysis facility for ESRD treatment, admission laboratory values may be used. (HbA1c and LDL within 1 Year of most recent ESRD episode).

◯ Prior lab values ◯ Admission lab values

LABORATORY TEST	VALUE	DATE	LABORATORY TEST	VALUE	DATE
a. Serum albumin g/dl	___.___		e. Hemoglobin g/dl	___.___	
b. Serum albumin lower limit	___.___		f. HbA1c	___.___	
c. Lab method used (BCG/BCP)	___.___		g. LDL	___.___	
d. Serum creatinine mg/dl	___.___		h. Cystatin C	___.___	

22. Does the patient have living will or medical/physician order for life sustaining treatment? ..... ◯ Yes ◯ No

23. Are you currently concerned about where you will live over the next 90 days? ..... ◯ Yes ◯ No

24. Do you have caregiver support to assist with your daily care? ..... ◯ Yes ◯ No
With home dialysis/kidney transplant? ..... ◯ Yes ◯ No
Does the caregiver live with you? ..... ◯ Yes ◯ No

25. Do you have access to reliable transportation? ..... ◯ Yes ◯ No

26. Do you understand health literature in English? ..... ◯ Yes ◯ No
Do you need a different way other than written documents to learn about your health? ..... ◯ Yes ◯ No
Do you need a translator to understand health information? ..... ◯ Yes ◯ No

27. Do you find it hard to pay for the very basics like housing, medical care, electricity, and heating? ..... ◯ Yes ◯ No

28. Within the past 12 months, has the food you bought not lasted and you didn't have money to get more? ... ◯ Yes ◯ No

29. Has anyone, including family and friends, threatened you with harm or physically hurt you in the last 12 months? ..... ◯ Yes ◯ No

B. Complete for all ESRD patients in dialysis treatment

30. Name of dialysis facility

31. CMS Certification Number (CCN) (for item 30)

32. Primary dialysis setting
◯ Home ◯ In-center ◯ SNF/LTC*

33. Primary type of dialysis
◯ Hemodialysis (sessions per week____/minutes per session____) ◯ CAPD ◯ CCPD ◯ Other

34. Date regular chronic dialysis began (mm/dd/yyyy)

35. Date patient started chronic dialysis at current facility (mm/dd/yyyy)*

36. Does the patient understand kidney transplant options at the time of admission?* ..... ◯ Yes ◯ No
◯ N/A (if patient answered yes to question 20(g)

37. If patient NOT informed of transplant options (or does not understand transplant options) please check all that apply:
☐ Patient found information overwhelming* ☐ Patient declined information ☐ Cognitive impairment*
☐ Patient has not been assessed at this time ☐ Patient has an absolute contraindication* ☐ Other

38. Has the patient been connected to a transplant center with a referral?* ..... ◯ Yes ◯ No
Date of referral (mm/dd/yyyy): _____
Name of transplant center: _____

39. Does the patient understand home dialysis options at the time of admission?* ..... ◯ Yes ◯ No
◯ N/A (if patient answered yes to question 20(f)

40. If patient NOT informed of home dialysis options (or does not understand home dialysis options) please check all that apply:
☐ Patient found information overwhelming* ☐ Patient declined information ☐ Cognitive impairment*
☐ Patient has not been assessed at this time ☐ Patient has an absolute contraindication* ☐ Other

*Go to instructions

C. Complete for all kidney transplant patients

41. Date of transplant (mm/dd/yyyy)

42. Name of transplant hospital	43. CMS Certification Number (CCN) (for item 42)

Date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of actual transplantation.

44. Enter date (mm/dd/yyyy)

45. Name of preparation hospital	46. CMS Certification Number (CCN) (for item 45)

47. Current status of transplant (if functioning, skip items 49 and 50)

◯ Functioning ◯ Non-functioning

48. Type of transplant:

◯ Deceased donor ◯ Living related ◯ Living unrelated ◯ Multi-organ ◯ Paired exchange

49. If non-functioning, date of return to regular dialysis (mm/dd/yyyy)

50.Current dialysis setting

◯ Home ◯ In-center ◯ SNF/LTC* ◯ Transitional care unit*

D. Complete for all ESRD self-dialysis training patients (Medicare applicants only)

51. Name of training provider

52. CMS Certification Number (CCN) of training provider (for item 51)	53. Date training began (mm/dd/yyyy)

54. Type of training

☐ Hemodialysis: (select one) a. ◯ Home b. ◯ In-center ☐ CAPD ☐ CCPD ☐ Other

55. This patient is expected to complete (or has completed) training and will self-dialyze on a regular basis. ..... ◯ Yes ◯ No

56. Date when patient completed, or is expected to complete, training (mm/dd/yyyy)

I certify that the above self-dialysis training information is correct and is based on consideration of all pertinent medical, psychological, and sociological factors as reflected in records kept by this training facility.

57. Printed name and signature of physician personally familiar with the patient's training

a. Printed name

b. Signature	c. Date (mm/dd/yyyy)

58. NPI of physician (for item 57)

*Go to instructions

E. Physician Identification

59. Attending physician (print)

60. Physician's phone number (include area code)	61. NPI of physician

Physician attestation

I certify, under penalty of perjury, that the information on this form is correct to the best of my knowledge and belief. Based on diagnostic tests and laboratory findings, I further certify that this patient has reached the stage of renal impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life. I understand that this information is intended for use in establishing the patient's entitlement to Medicare benefits and that any falsification, misrepresentation, or concealment of essential information may subject me to fine, imprisonment, civil penalty, or other civil sanctions under applicable Federal laws.

62. Attending physician's signature of attestation (same as item 59)	63. Date (mm/dd/yyyy)
64. Physician recertification signature	65. Date (mm/dd/yyyy)

66. Remarks

F. Obtain signature from patient

I hereby authorize any physician, hospital, agency, or other organization to disclose any medical records or other information about my medical condition to the Department of Health and Human Services for purposes of reviewing my application for Medicare entitlement under the Social Security Act and/or for scientific research.

67. Signature of patient (signature by mark must be witnessed.)	68. Date (mm/dd/yyyy)

If patient unable to sign/mark: (select one)

☐ Lost to follow-up ☐ Moved out of the United States and territories ☐ Expired date (mm/dd/yyyy)

G. Privacy statement

The collection of this information is authorized by Section 226A of the Social Security Act. The information provided will be used to determine if an individual is entitled to Medicare under the End Stage Renal Disease provisions of the law. The information will be maintained in system No. 09-700520, "End Stage Renal Disease Program Management and Medical Information System (ESRD PMMIS)", published in the Federal Register, Vol. 67, No. 116, June 17, 2002, pages 41244-41250 or as updated and republished. Collection of your Social Security number is authorized by Executive Order 9397. Furnishing the information on this form is voluntary, but failure to do so may result in denial of Medicare benefits. Information from the ESRD PMMIS may be given to a congressional office in response to an inquiry from the congressional office made at the request of the individual; an individual or organization for research, demonstration, evaluation, or epidemiologic project related to the prevention of disease or disability, or the restoration or maintenance of health. Additional disclosures may be found in the Federal Register notice cited above. You should be aware that P.L.100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

Northwest Kidney Centers Informed Consent for Treatment for Chronic Kidney Failure (ESRD) Patients

I have the right to make decisions about my healthcare. My kidney doctor (nephrologist) has explained to me that I have end-stage renal disease (ESRD) and that my kidneys no longer work well enough to support my health.

By signing this form, I authorize Northwest Kidney Centers (NKC) to treat my kidney failure with dialysis treatments at the direction of my kidney doctor and/or any other doctor appointed by him or her.

Information about my kidney failure (ESRD)

- My kidney doctor has explained my kidney failure to me
- I understand dialysis is one type of treatment for kidney failure; I may also choose to not start dialysis treatment, chose to stop dialysis later (will result in death), or to receive a kidney transplant
- My kidney doctor told me what to expect from dialysis, the effects of treatment, and the risks of dialysis treatments
- NKC provides the dialysis treatments my kidney doctor has ordered for me
- NKC staff are available to answer any questions I might have about my kidney failure and/or treatments and will support the choices I make regarding my treatment

Dialysis treatment options

NKC provides two types of dialysis treatments: hemodialysis and peritoneal dialysis (PD).

Hemodialysis

- Requires having access to my blood through a catheter or a vein
- Treatment can be done in a center or at home
- Blood moves through tubing from my body through a filter (dialyzer) connected to a dialysis machine
- Extra waste, salt, and water are removed in the filter, and then my blood is returned to my body

Patient Name _____ **NKC#** _____

Peritoneal Dialysis (PD)

- Requires having a tube placed in my abdomen
- Treatment is done at home
- A cleansing solution goes into my abdomen (belly) and draws out waste, salt and water from blood vessels
- The solution, along with waste and water, is drained out and replaced
- PD is done by doing several procedures by hand each day (CAPD), or with the help of a machine overnight while I sleep (APD)

Kidney function and dialysis

I know my kidneys are no longer able to clean the wastes and extra fluid from my blood. Since my kidneys do not work, I need dialysis as a lifesaving treatment. I am not able to live without dialysis. I have the right to choose which type of dialysis I receive after reviewing my options with my kidney doctor.

I understand I may be able to have hemodialysis or peritoneal dialysis in my home. If I am a candidate for home dialysis, NKC will train me to do my dialysis in my home. I understand I need a permanent access for NKC staff to train me for home dialysis.

I understand that I may change the type of treatment with the agreement of my kidney doctor and that I may need to change the treatment type for medical or other reasons in the future.

I understand that I will need to participate in care planning with my kidney doctor and NKC staff.

I understand that information about the payment for my dialysis treatments will be explained to me by my financial case manager.

I understand that during dialysis, a medication called heparin is used, which is derived from pork. I am aware I can refuse to have heparin given during my treatment and that my doctor will be contacted. I understand that NKC encourages me to discuss this matter or seek advice from my religious leaders if I have concerns.

Risks of dialysis

I understand that dialysis is a lifesaving treatment, but it also has risks which can be serious and even cause coma or death.

The risks can include:

- Low blood pressure (symptoms may include feeling weak or faint, headache, nausea, vomiting, chest pain or falls)
- Cramping from fluid removal (usually in legs, feet, hands)
- Chest pain
- Irregular or fast heart rate
- Fever and/or chills (may be a sign of infection)
- Infection of blood or dialysis access site
- Clotting of the blood at the access site, the dialyzer, or the blood tubing
- Bruising or bleeding due to blood thinning medications used in hemodialysis
- Allergic reactions which can cause itching or more serious symptoms
- Reactions and side effects from medications that are given during dialysis
- Hemodialysis equipment problems
- During the first peritoneal treatment, dialysate may cause some belly discomfort

NKC services

- Hemodialysis provided at an NKC dialysis center or training for home
- Laboratory draws to determine how well my dialysis is working for me
- Medications that are ordered by my kidney doctor to be given in-center or by me at home, will be administered during my dialysis treatment
- Care and services will be provided by NKC staff: nurses, technicians, social workers, dietitians, pharmacists, financial case managers, and other support staff as needed
- Doctors doing advanced studies in the care of kidney patients from the University of Washington may also take part in my care
- New employees or other students may provide care under the supervision of NKC staff

Unexpected medical needs

I know that during my treatment, unexpected situations may occur that require additional care. In these unusual circumstances, I authorize my doctor or his/her designee to order care for me to be performed by NKC staff.

Patient Name _____ **NKC#** _____

Financial responsibility (see also Patient Account Agreement)

I agree to pay for all services provided by NKC according to the then current rates and terms of the facility

I agree to apply for and use all available funding sources that are needed to pay for NKC charges and I understand that NKC will provide a Financial Case Manager to assist me with applications for funding sources, as necessary.

I agree to provide NKC with any financial and personal information needed to obtain and maintain coverage from funding sources. I agree to pay any applicable charges not paid by funding sources.

I agree to notify NKC about any changes in funding sources, including but not limited to, loss of or change in insurance coverage, eligibility for new coverage or enrollment in Medicaid or other programs.

Privacy of medical records (see also Notice of Privacy Practices)

I have received and understand the Northwest Kidney Centers Notice of Privacy Practices.

I understand that information in my medical record is protected and private and can only be shared under certain conditions that affect my medical care.

Duration of consent

I understand this consent will stay in effect for all treatments at any NKC facility, even if the care is interrupted (for example, by a hospital stay or travel). If I receive a kidney transplant or regain kidney function, this consent will stay in effect for three months following my last treatment at NKC. I can cancel this consent in writing at any time and NKC can cancel it in writing at any time.

Patient Name _____ **NKC#** _____

NORTHWEST Kidney Centers

Northwest Kidney Centers Informed Consent for Treatment for Chronic Kidney Failure (ESRD) Patients Acknowledgement

By signing this form I certify I have read, or someone else has read to me, the **Northwest Kidney Centers Informed Consent for Treatment for Chronic Kidney Failure (ESRD) Patients** (CKD-PE-37, 1/01/2023). I have received a copy, have had any questions answered, and I understand the information.

Signed:

Patient Name (Print)

x _____ _____
☐ Patient ☐ Legal Guardian/Representative ☐ Power of Attorney Date

Witness Name (Print)

x _____ _____
Witness Signature Date

x _____ _____
☐ Translator ☐ Reader Date

If this form is signed by someone else, there must be two witnesses:

Witness Name (Print)

x _____ _____
Date

JOINT NOTICE OF PRIVACY PRACTICES

This Joint Notice of Privacy Practices ("Notice") describes how medical information about you may be used and disclosed and how you can get access to this information. This Notice applies to all health information created or received by the medical staff, health care workers, employees, contract staff, students, trainees, and volunteers at Northwest Kidney Centers ("NKC").

For purposes of complying with the Health Information Portability and Accountability Act ("HIPAA"), NKC and its medical staff, which includes members of the Division of Nephrology from the University of Washington, designate themselves an Organized Health Care Arrangement ("OHCA"). They may share health information with each other for treatment, payment, and health care operations of the OHCA and as described in this Notice.

Personal Health Information About You

The following list identifies the different ways we may use and disclose your health information. In most cases, we will use and disclose only the minimum health information necessary for the purpose.

Treatment, Payment, and Health Care Operations

To Treat You: We may use and share health information about you to give you care and to manage your treatment or other services. For example, we may tell a doctor needing to perform surgery on you that you are on dialysis.

To Be Paid for Our Services: We may use and share health information about you to bill and collect payment for services received. We will get your authorization to disclose this information. For example, we may submit a bill to your health plan for care we provided you.

For Our Operations: We may use and disclose information about you to run our business. For example, we may use health information about you to review the quality of care we are providing.

Uses and Disclosures When You Do Not Object

We may use and disclose health information about you for the purposes below, but only after you have had the chance to object, unless otherwise permitted by law.

- To family and friends who are involved in your care or to notify familyand friends of your condition or location.
- To provide directory information (for example, to confirm you are in our facility).
- For emergency and notification purposes, such as to a disaster relief agency to coordinate disaster relief efforts.

Uses and Disclosures of Health Information Not Requiring Your Permission

We may use and disclose health care information for the following reasons without your permission.

- For public health and safety.
- For health and safety oversight activities.
- To other entities that we contract to assist us. We require these entities to protect the privacy and confidentiality of your health information.

- Incidental disclosures that happen during permitted uses and disclosures, such as someone in the waiting room hearing your name called.
- For education. We may send educational materials and newsletters to you to keep you informed about your care.
- For fundraising. We may contact you as part of a fundraising effort, but **you have the right to tell us you do not wish to receive fundraising communications**.
- To avert a serious threat to health or safety.
- For a court order, subpoena, search warrant, or other legal or law enforcement purpose.
- As de-identified information or part of a limited data set, after removing information that could be used to identify you, as allowed by law.
- To organ procurement organizations or persons who obtain, store, or transplant organs.
- For specialized government functions, such as for national security purposes.
- To correctional institutions, if you are in prison or in police custody.
- To report suspected child abuse or neglect or other abuse or neglect.
- To military or veterans' authorities if you are or were affiliated with the military.
- To coroners, medical examiners, or funeral directors to perform their duties.
- To comply with workers' compensation laws for workers' compensation claims.
- To personal representatives for minors and incapacitated adults.
- As otherwise required by law.

Additional Protections

We provide additional protections to your health information and may need your permission, as required by law, to share information related to AIDS/HIV, sexually transmitted and another communicable disease, drug and alcohol abuse, and mental health services.

Authorization

Other uses and disclosures will be made only with your authorization. For example, we need your permission to use and disclose health information for marketing; if we are receiving something of value for the health information; or psychotherapy notes. In most cases, you have the right to revoke or cancel your authorization, in writing, at any time.

Your Rights

You have personal rights concerning your health information. You may act on these rights by contacting your Northwest Kidney Centers Social Worker or the Northwest Kidney Centers privacy officer at:

Compliance & Privacy Officer
Northwest Kidney Center
12901 20th Avenue South
SeaTac, WA 98168
Phone: 206-720-8806
PrivacyOfficer@nwkidney.org

- You can file a complaint with at:

  U.S. Department of Health and Human Services
  Office for Civil Rights
  200 Independence Avenue, S.W.,
  Washington, D.C. 20201
  Phone: 877-696-6775
  https://www.hhs.gov/hipaa/filing-a-complaint/index.html

We will not retaliate against you for filing a complaint.

Additional Rights

Ask us to limit the information that we use and share: You have the right to ask us in writing to limit uses or disclosures of information about you for treatment, payment, and business purposes. We may deny your request in certain situations.

Request confidential communications: You have the right to receive confidential communications in other ways or at other locations. This includes a different mailing address or an email address.

Inspect and copy: In most cases, you have the right to look at health information about you or request a paper or electronic copy. You also may ask us to send an electronic copy of your health information to another person if your request is in writing, signed by you, and clearly says who the person is where to send the health information. We may charge a reasonable, cost-based fee.

Request changes: You have the right to request that we correct information in your record or add information you believe is missing. Wemay deny your request in certain situations.

Know about disclosures: You have the right to ask for and receive a list (called an accounting) of times where we have disclosed information about you, except for disclosures for treatment, payment, related business purposes, or other disclosures specified by law.

Receive a copy of this Notice: You have the right to receive a paper copy of this Notice, even if you received an electronic copy of this Notice.

Our Duties

We are required by law to keep health information about you private. We must give you this Notice of our legal duties and privacy practices, and we must follow the practices that are stated in the Notice. We will notify you if there is a breach of unsecured health information about you.

Changes to This Notice

We reserve the right to change this Notice. The revised Notice will be effective for information we already have about you as well as any information we receive in the future. Unless required by law, the revised Notice will be effective on the new effective date of the Notice. For a copy of the current Notice, please ask at one of our registration areas. The current Notice also is posted on our website (www.nwkidney.org) and in our facilities. The notice will state an effective date.

NORTHWEST Kidney Centers

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I am a patient or a personal representative of a patient of Northwest Kidney Centers. By signing this form, I acknowledge that I have been offered a copy of the Northwest Kidney Centers Joint Notice of Privacy Practices.

Name: _____

(Please Print)

Signature: _____

Date: _____

OR

I am the parent or legal guardian of:

_____

(patient name)

I hereby acknowledge that I have been offered a copy of the Northwest Kidney Centers Joint Notice of Privacy Practices with respect to the above-named patient.

Name: _____

(please print)

Relationship to Patient (please check one):

☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

NORTHWEST Kidney Centers

Home Dialysis Agreement

What you can expect from Northwest Kidney Centers:

- A team approach to your care—including your nephrologist, nurse, social worker, dietitian, and you
- Supplies and equipment for dialysis at home
- Training to safely do dialysis at home
- Follow up and monitoring to make sure you're doing well
- Nurse available by phone 24 hours per day, 7 days per week
- Home visits as needed
- Assistance with coordinating travel

Your responsibilities – what we expect of you:

- Complete your treatments as taught in training and as ordered by your nephrologist
  - Understand that your treatment plan may change over time
- Contact your dialysis unit with any problems or concerns
- Return phone calls
- Agree to home visits as needed
- Attend your scheduled clinic visits
- Take your medications as prescribed by your doctors and review them every month with your Home team
- Provide your height, weight and vital signs at clinic visits
- Schedule and keep monthly office visits with your nephrologist
- Complete your Home Dialysis Log each day; **must** include Blood Pressure and Weight
- Have regular monthly blood tests done, as well as other blood tests as requested
- Manage dialysis supplies as covered in your manual, including
  - Ordering supplies on time and in the right amounts
  - Rotating supplies by date and throwing out expired supplies
  - Storing and disposing of used supplies as taught

  Note: You may be responsible for courier fees associated with off schedule deliveries

- Let the unit know if you plan to have someone new help with your dialysis
- Participate in your Plan of Care
- Let the travel team know **60-120 days** before taking any trips
  - Advance notice is needed to schedule dialysis in other units or the delivery of supplies; follow the instructions in your training materials
- Notify your unit **60-120 days** before you plan to do dialysis treatments **outside of the United States or in another state**
  - Most insurance plans including Medicare/Medicaid will not reimburse for treatments outside of the United States, in other states, or on a cruise ship
  - If you travel outside the United States, you will be responsible for the cost of supplies and shipping, paid prior to departure
  - For PD patients, AMIA is only supported inside the United States and Canada (you will not have technical support in any other country)
  - HHD cannot be done outside of the United States, and you cannot travel internationally on NxStage

  Note: If you are travelling for greater than 30 days you will be required to transfer from NKC to another dialysis provider

If you plan to move:

- Check with the unit to make sure you will still be in the NKC service area
- If you are outside of the NKC service area, we will help you transfer to another dialysis center if necessary

If you do Home Hemodialysis:

- Have a phone available to reach 911 during dialysis
- Have must have access to the internet or have a telephone
- Do water and dialysis solution tests as requested
- Do dialysis with an adult person in the home, unless otherwise approved by the home program
- Your emergency alert device will be activated and available during your dialysis runs
- Complete all treatment logs daily; must include pre and post weights and blood pressures

If, at any time, there is an immediate danger to your health and safety, the care team will arrange for hemodialysis treatments in one of the NKC Facilities.

I have read, or someone else has read to me, the **Home Dialysis Agreement** (v01.24.2023). I have received a copy. I understand the information and agree to the responsibilities, expectations and terms.

Signed:

Patient Name (Print)

x _____ _____
☐ Patient ☐ Legal Guardian/Representative ☐ Power of Attorney Date

Witness Name (Print)

x _____ _____
Witness Signature Date

x _____ _____
☐ Translator ☐ Reader Date

NORTHWEST Kidney Centers

Home Dialysis Equipment Agreement

Northwest Kidney Centers (NKC) provides you with equipment to be used in your home.

Equipment includes items such as dialysis machines, water treatment systems, blood pressure monitors, warmers, carts, etc.. This equipment remains the property of NKC (or its authorized vendor) at all times.

As needed, we may substitute, replace, or repair these items.

Your responsibilities – what we expect you to do:

- Care for and use the equipment as instructed in your training and manuals
- Keep the equipment in a safe and secure place
- Allow NKC staff (and its authorized vendor staff) into your home, as needed, to work on the equipment
- Do not
  - Use the equipment for other purposes or for other people
  - Change the equipment in any way
  - Attempt to repair (or perform maintenance on) the equipment without instruction from NKC or its vendor
  - Lease, lend, sell, dispose of, or donate the equipment
- Notify us
  - When you receive new equipment
  - If the equipment is damaged or is failing to run correctly
  - If any fluids have leaked into the equipment
  - Plan to travel out of the state with the equipment
  - If you plan to move the equipment to a new address

By signing this form:

- I assume responsibility for the loss or damage to the equipment from obvious neglect, intentional damage, or improper use including damage to equipment occurring during travel.
- I agree to return the equipment no later than 30 days after discontinuing home dialysis or upon request. If equipment is not returned, NKC will purse appropriate legal action.

I have read, or someone else has read to me, the **Home Dialysis Equipment Agreement** (v9.06.2022). I have received a copy and I understand the information.

Signed:

Patient Name (Print)

x _____ _____
☐ Patient ☐ Legal Guardian/Representative ☐ Power of Attorney Date

Witness Name (Print)

x _____ _____
Witness Signature Date

x _____ _____
☐ Translator ☐ Reader Date

NORTHWEST Kidney Centers

Home Dialysis Safety Agreement

You need to take certain steps to protect your safety, the safety of others, and your personal property when doing dialysis at home.

Northwest Kidney Centers encourages you to have homeowner's or renter's insurance. We want you to have this protection in the unlikely chance that your home or personal property is damaged.

We do not provide any coverage for damage to your home or personal property—it is your responsibility.

Your responsibilities – what we expect you to do:

- Clean with bleach (one-part bleach to 100 parts water)
  - Your equipment after every dialysis
  - Any blood or body fluid splashed on the floor, chairs, etc.
- Make sure your dialysis area is well lit
- Dispose of any used dialysis supplies (including needles) as instructed
- Place dialysis equipment away from heaters, wood stoves or air conditioner
- Before each treatment, check the dialysis and equipment lines for problems
  - This includes drain lines plus blood and water lines for Home Hemodialysis
- Take steps to prevent someone from tripping on something
  - Secure all lines and cords
  - Keep walkways free of garbage and supplies
- Store supplies as instructed in training materials
- When NKC staff (including delivery personnel, vendors, etc.) are in your home
  - Let staff know if anyone is sick in your home
  - Keep all pets contained
  - Remove any weapons from the dialysis area
  - Do not smoke
  - Have someone be in the home
- Threats, violence, or other illegal activities are not tolerated while staff is present

NORTHWEST Kidney Centers

If you are on Home Hemodialysis, we also expect you to:

- Have enough space around the dialysis equipment for work to be done
- **Important***:* Do not ever use an extension cord for home hemodialysis
- Cover any carpet under the dialysis equipment with a rigid, washable surface, such as a desk chair floor protector
- Do your dialysis at the location identified in your home survey
- Use the identified outlet, water supply and drain, and backflow preventer

These requirements help provide for a safe home dialysis setting and prevent unnecessary damage to your home and property. If at any time you fail to meet these requirements, it may not be possible to continue dialyzing at home.

By signing this form:

- I understand that performing dialysis in a home setting involves potential risk of damage to my home and personal property.
- I acknowledge that I have been encouraged to obtain the appropriate homeowner's or renter's insurance to cover any damage that may occur to my home or personal property.
- I understand that Northwest Kidney Centers assumes no responsibility for my home or personal property.

I have read, or someone else has read to me, the **Home Dialysis Safety Agreement** (v9.06.2022). I have received a copy and I understand the information.

Signed:

Patient Name (Print)

x _____ _____
☐ Patient ☐ Legal Guardian/Representative ☐ Power of Attorney — Date

Witness Name (Print)

x _____ _____
Witness Signature — Date

x _____ _____
☐ Translator ☐ Reader — Date

NORTHWEST Kidney Centers

Home Programs ESA Agreement

Erythropoiesis-Stimulating Agents (ESA) are a very important part of your treatment. Giving it to yourself as instructed by your nurse makes a big difference in your overall health, and how you feel. Like most medications, it must be taken correctly to avoid problems.

- Your nurse will tell you **how much ESA to take** and **on what days**
- Your ESA will be sent to you as needed by our pharmacy
- If you are not going to be home to get your ESA in the mail, contact the pharmacy
- At your monthly clinic and whenever your ESA changes, your nurse will ask for what you have on hand at home
- Contact your nurse if:
  - You take the wrong amount
  - You missed a shot of ESA because of a hospitalization or another reason

Your nurse must make sure you are taking your ESA safely at home.

If you are unable to manage your ESA, arrangements will be made for you to come to the home dialysis unit to receive your ESA.

I have read, or someone else has read to me, the **Home Programs ESA Agreement** (v9.06.2022). I have received a copy and I understand the information.

Signed:

_____
Patient Name (Print)

x _____ _____
☐ Patient ☐ Legal Guardian/Representative ☐ Power of Attorney Date

_____
Witness Name (Print)

x _____ _____
Witness Signature Date

x _____ _____
☐ Translator ☐ Reader Date

NORTHWEST Kidney Centers

Special Instructions for Supply Orders and Deliveries

It is important for you to manage your supplies as covered in your manual, including

- Ordering supplies on time and in the right amounts
- Rotating supplies by date and throwing out expired supplies
- Storing and disposing of used supplies as taught
- Making plans to receive supplies
- **Call your Home Program Coordinator for urgent supply needs <u>or if you miss your regular scheduled order date</u>**
- **Note:** If you call Baxter or NxStage directly for any URGENT supply needs, you may be responsible for delivery fees associated with those supplies.

Plan ahead—some deliveries require someone to be home. If you are not at home to receive a delivery, the driver may contact the Home Program for further instructions.

Choose One Option

☐ **Do** authorize the driver to leave the supplies at the location below:
Location _____

Important: The location should be covered, dry, and accessible to the driver. It is your responsibility to move the supplies into your home. Supplies should not be left outside for long periods of time or in extreme temperatures.

☐ **Do not** authorize the driver to leave supplies. I will need to arrange to pick up my supplies with my Home RN.

Signed:

_____
Patient Name (Print)

x _____ _____
☐ Patient ☐ Legal Guardian/Representative ☐ Power of Attorney Date

_____
Witness Name (Print)

x _____ _____
Witness Signature Date

x _____ _____
☐ Translator ☐ Reader Date

Patient Name **NKC #**

NORTHWEST Kidney Centers

Patient Portal Account Registration

Welcome to the NKC Patient Portal, our new web program for home dialysis patients.

This application gives you a secure, round-the-clock way to track your dialysis, and access parts of your medical record. As technology permits, NKC may expand web access to your medical record.

Please complete this form to register for an account.

We encourage you to not share your User ID and Password with others. Please notify us immediately if you believe this information is no longer secure.

Patient Name (print): _____

Email Address*: _____

* The application sends notifications (including password reset information) to this email address. You may change this email in the application at any time.

By signing this form:

- You are authorizing Northwest Kidney Centers to create a Northwest Kidney Centers account associated with the email address listed above.

Signed:

_____
Patient Name (Print)

x _____ _____
☐ Patient ☐ Legal Guardian/Representative ☐ Power of Attorney Date

_____
Witness Name (Print)

x _____ _____
Witness Signature Date

x _____ _____
☐ Translator ☐ Reader Date

NORTHWEST Kidney Centers

Patient Appointment and Notification Authorization

Welcome to Northwest Kidney Centers **Appointment+**, our appointment notification system for home dialysis patients.

This application gives you the ability to receive text or email notifications of upcoming appointments.

Please complete this form to authorize Northwest Kidney Centers to text and/or email you of upcoming appointments.

Patient Name (print): _____

Email Address: _____

Mobile/Cell Number: _____

By signing this form:

- You are authorizing Northwest Kidney Centers to Text or Email the above email address or mobile/cell phone number with appointment information.

Signed:

_____
Patient Name (Print)

x _____ _____
☐ Patient ☐ Legal Guardian/Representative ☐ Power of Attorney Date

_____
Witness Name (Print)

x _____ _____
Witness Signature Date

x _____ _____
☐ Translator ☐ Reader Date

NORTHWEST Kidney Centers

Clarity Patient Portal Registration Instructions: Step-By-Step

- Open either Microsoft Edge or Google Chrome internet browser
- Log in to Clarity EMR with your credentials
  https://clarity.visonex.net
- Select **Registration** tab → General Information
- Find and select patient
- Scroll to the bottom of the page, select **Patient Portal Registration**
- Type the **Username** for patient using the following cadence:
  "firstname.lastname#### (year of birth)"
- Select **Submit**
- Write down **Registration Code** for patient on the *Patient Portal Sign-up Information* sheet
- Log out of Clarity EMR site
- Go to https://patient.visonex.net/visonex/patientportal
- Select **I have a registration code** (located under the blue **I Accept** button)
- Fill in the **Username** and **Registration Code**
- Select **Next**
- Enter **Email**, **Security Pin**, and **New Password** (phone number is not required)
- Select **Next**
- Enter information for **Security Questions 1-3** as listed on the *Patient Portal Sign-up Information* sheet
- Select **Complete User Registration**
- Ask patient to log in to their personal email account with you and **finish setup by selecting the link sent via email**
- Portal registration is complete

NORTHWEST Kidney Centers

Patient Portal Sign-up Information

Use the information below to access your online medical record through the Northwest Kidney Centers Patient Portal, our web program for home dialysis patients.

To access the site, go to https://patient.visonex.net/visonex/patientportal

Patient Name: _____

Registration Code: _____

Username: _____

Password: _____

Security Questions:

Question 1: _____

Answer: _____

Question 2: _____

Answer: _____

Question 3: _____

Answer: _____

NORTHWEST Kidney Centers

Peritoneal Dialysis Program Equipment Record

Equipment – INITIAL ISSUE	
Equipment	**Serial #**
Amia Cycler	
Baxter Cycler – Home Choice	
Baxter Cycler – Claria	
NKC Chair Scale	

The following items were provided:	
Blood Pressure Monitor	☐ Yes ☐ Personal
Weight Scale	☐ Yes ☐ Personal
Digital Thermometer	☐ Yes ☐ Personal
Heating Pad	☐ Yes
Spring Scale	☐ Yes
I.V Pole	☐ Yes
PPE for Caregiver(s)	☐ Yes ☐ N/A

Service Swaps & Final Pickups ONLY	
Equipment	**Serial #**
NKC Chair Scale	
Issued	
Returned	

FINAL PATIENT PICKUP	
Chair Scale	☐ Returned

Staff Instructions: Complete this form when issuing any equipment to patients.

Staff Name (printed) _____ Staff Signature _____ Date _____

Patient Name _____ NKC # _____

GET READY FOR PD

Starting Peritoneal Dialysis

- ☐ **Lifestyle options of PD**
  - PD is therapy you do at home
  - Your PD treatment schedule may be set to match your lifestyle
  - Doesn't involve blood and needles during treatment
  - Offers opportunity to travel

- ☐ **What normal kidneys do**
  - Clean blood to remove excess waste and water
  - Keep body chemicals in balance
  - Control blood pressure and help make red blood cells

- ☐ **When kidneys fail**
  - Waste products build up in the blood
  - Body fluids are no longer in balance

- ☐ **Uremia**
  - A build-up of waste products in the blood when kidneys are not working
  - Common uremia symptoms

- ☐ **What is peritoneal dialysis (PD)?**
  - Peritoneal membrane along with the PD solution filters and cleans the blood
  - PD can relieve many of the symptoms of uremia

- ☐ **The PD catheter**
  - Permanent access for PD treatments
  - Small flexible tube surgically placed into space called peritoneal cavity
  - A transfer set is used to connect the PD catheter to tubing for the PD solution to fill and drain from the peritoneal cavity
  - Transfer set remains connected to your catheter and is changed only by PD nurse

- ☐ **What is a PD exchange?**
  - PD exchange removes used PD solution containing waste products and fluid from the body and replaces it with new solution from the peritoneal cavity
  - Each exchange has three steps: drain, fill and dwell

- ☐ **Performing PD at home**
  - CAPD and APD are two ways to do PD at home

- ☐ **How CAPD works**
  - CAPD is a manual method of PD using gravity to drain and fill dialysis fluid through PD catheter
  - CAPD exchanges are performed by you, usually four times a day
  - Drain and fill steps of each exchange take about 30 minutes
  - During dwell phase, you go about your normal routine until the next exchange

- ☐ **How APD works**
  - A cycler is used at night during sleep
  - Another PD exchange may be needed during the day

- ☐ **Sexuality and PD**

YOUR DAILY ROUTINE

Keeping Clean

- ☐ **Always wash and dry hands before**
  - Doing exit-site care
  - Gathering your CAPD supplies
  - Connect and disconnect from your PD exchange

- ☐ **Patient demonstrates steps of correct hand washing**
  - Use clean running water and liquid soap in pump dispenser
  - Wash well between fingers and underneath nails
  - Rub hands vigorously
  - Dry hands completely with disposable paper towel
  - Use paper towel to turn off faucets

- ☐ **After hand washing, be careful what to touch**
  - Hand washing makes the hands clean, not sterile
  - After hand washing:
    - Touch only PD supplies and equipment
    - If you touch something else, wash and dry your hands again, or use hand sanitizer

- ☐ **Using hand sanitizer**
  - Alcohol-based hand sanitizer should be used, in addition to regular hand washing, to keep hands clean for PD treatment
  - Use hand sanitizer after you disconnect when PD treatment is completed
  - Patient demonstrates correct use of hand sanitizer
    - Apply enough hand sanitizer to cover and clean your entire hand
    - Rub hands together thoroughly
    - Rub hands together until they are dry

- ☐ **Clean Environment for PD**
  - These words describe the clean environment needed for PD
    - Clean — You have removed most, but not all, germs
    - Sterile — Item is free of germs
    - Aseptic technique — Reduces risk of contamination of sterile PD equipment
    - Contamination — Happens when germs are introduced into a clean or sterile object or environment

- ☐ **Good cleanliness technique helps keep germs out of peritoneal cavity**
  - Wear a mask when doing a CAPD treatment
  - Wash and dry hands before every treatment
  - Don't cough or sneeze on sterile supplies
  - Keep pets out of room during PD, off your bed, and away from CAPD supplies
  - Perform catheter care as instructed by your PD nurse
  - Keep clothes, bedding, equipment clean

- ☐ **Areas where contamination can occur during CAPD**
  - Exposed or opened end of transfer set
  - Open end of CAPD system after pull ring is removed
  - Medication port (if medication is added to solution bag)

- ☐ **Problems with accidental contamination and what to do**
  - Sterile connections are touched: Throw them away, start with new supplies
  - Open end of transfer set is touched or dropped: Close clamp, cap it, and call PD nurse, as directed
  - Inside of disconnect cap is dropped or touched: Throw out, then start again with new disconnect cap

Setting Up for CAPD in Your Home

- ☐ **Things to consider at home for CAPD**
  - Table/surface for performing an exchange
  - Storage for PD supplies
  - Good source of light
  - Access to a phone
  - IV pole or place to hang solution bag

- ☐ **Other requirements for the rooms**
  - Room should be quiet and distraction-free
  - No pets in the room
  - Doors, vents and windows closed
  - Fans turned off
  - Germ-killing cleanser used for counter or table top where exchange is being performed
  - You can travel with CAPD; use the same room set-up guidelines as at home and follow aseptic technique

- ☐ **7 Steps for hand washing/gelling**

Taking Care of Your PD Catheter and Exit Site

☐ **Exit site care — check your PD catheter and transfer set**

- Transfer set is tubing that connects to your catheter
- Wash and dry your hands before caring for your catheter and exit site
  - Check catheter and transfer set once exit site is healed, before each treatment, and each time you do exit site care
  - Catheter and transfer set should be free of tears, cracks, slits, and holes
  - Catheter and transfer set should be immobilized
  - Make sure connection of catheter to transfer set is tight
  - Your nurse will change the transfer set about every six months
  - If you note a problem, do not proceed with PD treatment

☐ **Gathering supplies for exit site care**

- Gauze or clean washcloths
- Liquid antibacterial soap or cleaning agent
- Antibiotic cream or ointment
- Cotton-tip swabs or gauze
- Tape or bandage
- Immobilizing device

- ☐ **How to care for your PD catheter and exit site**
  - Exit site care is important to help avoid infection
  - Start by checking your exit site
    - It should not be red, painful, swollen, or have drainage
    - Feel around the catheter tunnel, where the catheter tunnels under the skin to where it exits the body
    - Tunnel should not be tender or swollen
  - Wash and dry your exit site
    - Start washing close to the catheter, washing in a circle around and away from catheter
    - Rinse completely
    - Dry skin close to catheter, drying in a circle around and away from catheter where it exits the body
  - Leave crusts and/or scabs in place
  - Place antibiotic cream or ointment and secure exit site
    - Put pea-size amount of cream/ointment on swab or gauze, then put cream/ointment on exit site
    - Secure your catheter
    - If exit site gets wet or dirty, repeat exit site care
  - Secure catheter while you sleep; this prevents accidental pulling or tugging
    - Your nurse will show you how to secure catheter
    - Immobilizing device or tape may be suggested

How to Identify Signs and Symptoms of Exit Site Infection or Peritonitis

- ☐ **Exit site infection**
  - Healthy site is normal in color and has no drainage
  - Infected site may be red, tender, swollen, or have drainage

- ☐ **Peritonitis**
  - Cloudiness in PD drain bag and fibrin may be seen
  - Symptoms: feeling sick, fever, stomach pain

- ☐ **When to call the PD nurse**
  - Problems with catheter or transfer set
  - Problems with exit site or tunnel
  - Possible peritonitis
  - When your belly doesn't feel right

- ☐ **What to do if you have a problem with your PD catheter or exit site**
  - Redness, drainage, swelling, or soreness at exit site; call PD nurse, as directed
  - Irritation around exit site: Secure your catheter to prevent tugging; call PD nurse, as directed
  - Tunnel infection: If there is redness, drainage, swelling, or soreness in area along catheter; call PD nurse, as directed
  - A crack, slit, or hole in the transfer set: Put a clamp on the transfer set and call PD nurse immediately
  - Leaking around the exit site: Call your PD nurse immediately, and do not do any PD exchanges until you have talked to your nurse
  - A hole or crack in your catheter: Put a clamp on the catheter between the hole or crack and yourself, call your PD nurse immediately, and do not do any PD exchanges until you have talked to your nurse
  - Cloudy drained solution, fibrin, stomach pain, fever, feeling sick (nausea, vomiting): Call your PD nurse immediately, check if you have cloudy fluid in the drain bag, and save the cloudy bag

- ☐ **Your PD access**
- ☐ **Protecting your PD access in water**
- ☐ **Blood pressure**
- ☐ **Taking your blood pressure**
- ☐ **Metric system for PD patients**

DOING EXCHANGES

Steps for a Safe Treatment

- ☐ **Three things to do before every PD treatment**
  - Weigh yourself and record weight
  - Take blood pressure and record it
  - Do a physical assessment
- ☐ **Clean, aseptic and sterile**
  - Clean: most, but not all, of the germs have been removed
  - Aseptic technique: reduces the risk of contamination of sterile PD equipment
  - Sterile: completely free of germs
- ☐ **Sterile supplies that should not be touched**
  - Inside of the MiniCap disconnect cap
  - Transfer set tip, after the MiniCap disconnect cap is removed
  - Patient connector end of the UltraBag System, after the pull ring is removed

☐ **Common areas where contamination can occur**

- Connection to UltraBag System
- Ports on solution bags
- Connection to your transfer set

Get Ready for Your PD Treatment

☐ **1. Prepare the work area**

- Appropriate work area for PD preparation is identified
- Approved cleaning agent is used to clean the work area

☐ **2. Gather supplies for CAPD**

- Mask
- Hand sanitizer
- UltraBag Solution Delivery System
- Two red UltraBag tubing clamps
- MiniCap disconnect cap

☐ **3. Use aseptic technique**

- Wear a mask
- Wash and dry hands thoroughly
  - After hand washing, touch only PD supplies and equipment
  - If something else is touched after hand washing, wash and dry hands again, or use hand sanitizer

☐ **4. Check the PD solution bag using SEAL**

- S — Strength of the solution
- E — Expiration date
- A — Amount (correct volume of PD solution)
- L — Leaks are not present
- Also check frangibles in solution bag to be sure frangibles are intact

☐ **5. Do final checks on each bag before exchange begins**

- PD solution is clear
- Medication port and pull ring are in place
- Also check frangibles in solution bag to be sure frangibles are intact
- All three must be OK. If not, discard bag and replace it with one that meets the checks

☐ **6. Prepare to connect and disconnect**

- Use aseptic technique when handling UltraBag System and supplies
- Place the transfer set so it can be reached easily
- Put on a mask
- Wash and dry hands

☐ **7. Start your recommended CAPD connection procedure**

- Perform the PD treatment following all instructions

What to Do After Your PD Treatment

- ☐ **Disposal of waste materials**
  - After treatment, empty fluid from drainage bag into the drainage area, then clamp or tie lines to prevent leaks
  - Place materials in a tightly sealed garbage bag before discarding with household trash, if allowed
  - Recycle boxes and overpouches, if applicable

- ☐ **Problem of PD solution not flowing in or out and what to do**
  - One or more clamps may be closed: During drain — make sure there is no UltraClamp tubing on the drain line and the transfer set twist clamp is open. During fill — make sure there is no UltraClamp tubing on the fill line and the transfer set twist clamp is open.
  - Tubing or catheter is kinked: Straighten out the tubing and the catheter.
  - Catheter, tubing, or frangible is blocked by fibrin: Gently squeeze the line or bend the frangible back and forth to loosen the fibrin and allow fluid to pass. Call your PD nurse.
  - Constipation: Talk to your PD nurse or dietician about your diet and ways to prevent constipation.
  - Air in the CAPD system fill line: Close the transfer set twist clamp, remove the clamp from the drain line, gently squeeze the solution bag, and observe air and fluid flowing to the drain bag. Then reclamp the drain line, open the transfer set clamp, and try to fill again.

- ☐ **Problems with drained solution and actions to take**
  - Drained fluid is cloudy: Call PD nurse ASAP. Do not wait for next exchange. Save fluid in drain bag and bring to dialysis unit or emergency department.
  - Drained fluid has white strands: call PD nurse, as directed.
  - Drained fluid is pink: Call PD nurse, as directed.
  - Drained fluid is dark yellow, but clear: Discuss with or call your PD nurse.

- ☐ **Problem of solution leaking during an exchange and what to do**
  - CAPD system tubing came apart from the transfer set: Close the transfer set and place a new MiniCap disconnect cap. Do not complete the exchange, and call your PD nurse immediately.
  - Transfer set came apart from the catheter: Place a clamp on the catheter to stop the drainage, and do not complete the exchange. Close the transfer set clamp, disconnect from the exchange system, put on a new MiniCap disconnect cap, and call your PD nurse immediately.
  - Hole in the exchange system: Close the transfer set clamp and disconnect from the exchange system. Put on a new MiniCap disconnect cap and call your PD nurse immediately.

- ☐ **Problem of solution being too cold, flowing too fast, or air in the patient's line**
  - Solution is too cold: Warm the solution bags as instructed, drain the cold solution, and inflow the warmed solution. If pain continues, call your PD nurse immediately.
  - Solution is flowing into the peritoneal cavity too fast and is associated with abdominal pain or discomfort: Partially close the transfer set clamp or lower IV pole.
  - Air in the patient line: Always flush the lines as instructed. If pain continues, call your PD nurse.

- ☐ **Protection for PD helpers**

- ☐ **Importance of following steps—CAPD exchange**

- ☐ **CAPD exchange—key points**

- ☐ **What to do about accidental contamination**

CONTACTS

- ☐ **Important phone numbers**
- ☐ **How to contact your PD team**
- ☐ **Getting help**
- ☐ **Maps and directions to PD clinics and the distribution center**

PROBLEM GUIDE

- ☐ **Emergency kits**

Making Decisions At Home About Your Care—Patient demonstrates the ability to make the correct decision about care in the following problems:

- ☐ **Problems during your treatment**
  - I cannot fill or drain
  - My solution is too cold and I feel abdominal pain or discomfort
  - My solution is flowing into the peritoneal cavity too fast and I feel abdominal pain or discomfort
  - My catheter, tubing, or frangible is blocked by fibrin
  - My drained fluid is cloudy
  - My drained fluid is clear but it has white strands (fibrin) in it
  - My drained fluid is pink
  - My drained fluid is dark yellow
  - I have cramping or pain during drain

☐ **Possible contamination**

- There is a crack or hole in my catheter or transfer set
- My transfer set came apart from the catheter
- The PD system tubing came apart from my transfer set during an exchange
- There is a hole in the exchange system
- I touched or dropped the open/exposed end of my transfer set
- I accidentally touched the sterile parts while making a connection

☐ **Problems with your catheter or exit site**

- There is a leak around my exit site
- I have irritation around the exit site
- I have symptoms of an exit site or tunnel infection such as redness, tenderness/pain, or drainage at the exit site

☐ **Other problems**

- I have stomach pain and/or a fever
- I have symptoms of uremia such as loss of appetite and fatigue, even though I am doing my exchanges
- I am not urinating as much
- I am having trouble keeping to my exchange schedule
- I have symptoms of the flu, common cold, or cough
- I am constipated
- I have shoulder pain

☐ **Hernias**

☐ **Potassium: too high or too low**

MANAGING FLUID

- ☐ **Fluid in your body**
  - Fluid weight
  - Body weight
  - Fluid Weight + Body Weight = Total Weight

- ☐ **What affects fluid in your body when your kidneys don't work**
  - Salt (sodium) you consume affects how much fluid you drink and retain
  - Fluid you drink or eat
  - Urine output
  - Amount of fluid removed by PD
  - Your PD nurse and/or dietician will help you set how much fluid you can drink each day
  - Patient understands daily amount of fluid to drink

- ☐ **How fluid balance affects your health**
  - Keeping fluid in balance helps you and your physician manage your health
  - Too much fluid can lead to swelling, high blood pressure, trouble breathing or rapid weight gain
  - Too little fluid can lead to low blood pressure, dizziness, nausea or rapid weight loss

- ☐ **Fluid balance is important because it may help you avoid issues such as:**
  - Too much fluid (fluid overload)
  - Too little fluid (dehydration)
  - If you notice more or less urine output, call your PD nurse, as directed

☐ **Checks to do every day**

- Weigh yourself and record it
  - Your PD physician and nurse will determine your target weight
- Take your blood pressure as you were taught and record it
- Record your ultrafiltration information if you use a cycler
- Record this information on your home treatment record sheets or as directed. Bring these records to your next doctor visit

☐ **Checks to do every day (continued)**

- Urine output: keep track of it
- Swelling: check morning and later in the day around your eyes and in your hands, lower legs, ankles
- How you feel
- Tell your PD nurse if you have symptoms of sudden weight gain or weight loss, high or low blood pressure, swelling, difficulty breathing, dizziness, or nausea.

☐ **Fluid overload**

- Fluid overload is having too much fluid in your body
- Can occur when PD treatments remove too little fluid from your body, when you drink too much fluid, or your urine output decreases.
- Fluid overload may cause some or all of these symptoms:
  - Rapid weight gain
  - High blood pressure
  - Swelling and puffiness in your face and around eyes, hands, lower legs and ankles, especially in the morning and evening
  - Tightness in rings, waist bands, shoes
  - Trouble breathing when walking, climbing stairs, lying down

☐ **What to do for fluid overload**

- Consume less fluid
  - Divide your fluid for the day between meals and snacks
  - Know how much fluid a cup or mug holds and use it all the time
  - Talk to your PD nurse about using a higher-strength PD solution and how long you should use it
  - Limit salt intake
- If your symptoms do not improve, call your PD nurse as directed

☐ **Dehydration**

- Dehydration is having too little fluid in your body
- Can occur when PD treatments remove too much fluid from your body, if you are not drinking enough fluid, or if your urine output increases.
- Symptoms: rapid weight loss, low blood pressure, feeling dizzy or sick, nausea or vomiting

☐ **What to do for dehydration**

- Consume more fluid
- Talk to your PD nurse about using a lower-strength PD solution and how long you should use it
- Eat salty foods like crackers
- If your symptoms do not improve, call your PD nurse as directed

- ☐ **Choosing PD fluids**
  - There are three strengths of dextrose (sugar) dialysis solution
  - The numbers tell you how much dextrose the bag contains
  - Solution with higher amount of dextrose removes more fluid from your body than solution with lower amount of dextrose
    - 1.5% - Low dextrose solution, which removes the least amount of fluid
    - 2.5% - Mid-range solution
    - 4.25% - High dextrose solution, which removes the most fluid compared to 1.5% and 2.5% dextrose solutions
  - Your PD nurse will work with you to select the best solution strength for your needs
  - For some treatments, you may use two different concentrations of solution or all of the same strength
  - Talk to your PD nurse if you have questions about solution or about choosing a higher or lower strength solution

- ☐ **Using "My Guide for PD Treatments" to choose strength of PD solution**
  - Factors to record in chart:
    - Weight
    - Blood pressure
    - Body swelling

MANAGING YOUR CARE

- ☐ **Medications and labs**

- ☐ **Your clinic visit**

- ☐ **Preparing for medical procedures**

Ordering Your Peritoneal Dialysis (PD) Supplies

☐ **Information booklet on PD supplies**

- "Managing Your PD Supplies at Home" booklet from Baxter HomeCare Services provides details on ordering, delivery, storage, disposal, travel, and support questions
- Keep the booklet and refer to it when you have questions
- Booklet has important phone numbers for contacting Baxter HomeCare Services

☐ **First supply and equipment order**

- Dialysis unit determines your supply order
- Dialysis unit places your first order of supplies and equipment
- First order will be largest and may include:
  - Dialysis machine
  - Blood pressure cuff
  - Scale
  - 25 or more cases of PD solution
  - Tubing sets and other disposable products
  - IV pole

☐ **Ordering your supplies**

- Use delivery schedule to see when to place order and when order will be delivered
- Count and record the number of unopened boxes you have on hand
- Place order at least ten business days before scheduled delivery date
- Call Baxter HomeCare Services Representative and use inventory form to place order
- You will get pre-delivery phone call from HomeCare Services telling you the delivery date and time

☐ **When your delivery arrives**

- Baxter Service Specialist will:
  - Bring supplies into your home
  - Rotate boxes on request
  - Ask for your signature

☐ **Check delivery**

- Use the packing list to check that delivery is correct, noting:
  - Number of cases
  - Solution strength
  - Other supplies

☐ **Also check supplies for:**

- Holes or damage to cases
- Wrapping and sealing of sterile supplies
- Expiration date has not passed

☐ **Emergency supplies**

- If you need emergency supplies, call your PD nurse, as directed
- Ordering supplies outside your normal timeframes may add unwanted charges and fees

- ☐ **How to store your supplies**
  - Store in clean, dry area
  - Store at room temperature, avoiding extreme heat or cold
  - Keep supplies in original cartons
  - Keep away from pets, insects, rodents
  - Place oldest supplies in front to use first
  - If supplies are delivered by a Baxter Service Specialist, that employee will rotate supplies, upon request
  - Do not store supplies outside (sheds or garages may be acceptable)

- ☐ **Issues with supply order and action to take**
  - Supplies will run out before next delivery: Call your PD nurse, as directed
  - Ordered or delivered supplies, PD solution volume, or dextrose concentration was incorrect or not part of your order: Refuse portion of delivery that was wrong: Call your PD nurse or Baxter, as directed
  - Inventory count was wrong, or delivery was short of supplies: Call your PD nurse or Baxter, as directed

- ☐ **Traveling with PD**
  - Use the Travel Checklist to ensure you have all of your supplies
  - Baxter will send only full boxes of solution, cassettes, and caps
  - Partial boxes and remainder of supplies must be brought by patient

YOUR LABS

- ☐ **Understanding your monthly labs**

- ☐ **PD adequacy**

- ☐ **Your PET (Peritoneal Equilibrium Test)**

YOUR MEDICATIONS

Understanding Your Medications

☐ **Medications and You**

- Medications are an important part of your treatment, determined by your kidney doctor
- Always follow the medication instructions from your kidney doctor or PD nurse
- Don't take any medications that were not prescribed/ ordered by your kidney doctor, including laxatives, vitamins or herbal supplements
- If you get a new medication from a doctor other than your kidney doctor, call your PD nurse before taking it
- Keep a list of all medications, dosages and drug allergies with you at all times. Include PD solutions on the list of your medications

Common medications and why they are important

☐ **Erythropoietin – to help make more red blood cells**

- When kidneys fail, they no longer make enough of this hormone
- Too few red blood cells cause anemia
- Your PD nurse may give you an erythropoietin injection. Or, you may be trained to give it to yourself at home

☐ **Iron – to help make red blood cells**

- Iron pills or iron infusions may be needed to increase amount of iron in your blood
- Iron must be taken exactly as your doctor prescribed
  - Don't take with phosphate binders, antacids, or milk
  - Iron pills work best when taken on empty stomach
  - If you get an upset stomach, check with doctor or PD nurse

- ☐ **Stool softeners – to promote easier bowel movements**
  - Constipation can interfere with PD treatment and cause PD catheter to work poorly
  - Contact PD nurse if you become constipated

- ☐ **Blood pressure medications – to control blood pressure**
  - Your doctor will prescribe the type and amount you need
  - Follow your schedule for taking your blood pressure medication

- ☐ **Phosphate binders – to remove phosphorus from the body and keep bones healthy**
  - When kidneys don't work, they can't remove phosphorus
  - Many types exist; your doctor will prescribe best one for you
  - Must be taken with meals or snacks to be effective

- ☐ **Vitamin D – to keep bones strong and healthy; works with calcium**
  - When kidneys fail, active form of vitamin D in body decreases

- ☐ **Adding medications to dialysis solution**
  - Your PD nurse will give you information and training on this, if needed
    - Heparin
    - Antibiotics
    - Insulin

- ☐ **Heparin – to help maintain catheter flow when fibrin is present**
  - Fibrin is white material that can be present in drained PD solution. It is often present in patients with peritonitis
  - Call your PD nurse if you notice fibrin in your drained PD solution
  - Not all patients need heparin

- ☐ **Antibiotics – to treat an infection**
  - Your doctor will prescribe best antibiotic for you
  - Take antibiotic as prescribed and until all doses are taken
  - If antibiotic is added to solution bag, add it for the designated number of days

- ☐ **Insulin – to help maintain blood sugar levels (for some diabetics)**
  - Your PD nurse will instruct you how to take insulin

- ☐ **Your clinic visit**

- ☐ **Preparing for medical procedures**

- ☐ **IV iron**

- ☐ **Anemia**

- ☐ **Home preparation of Mircera**
- ☐ **Giving yourself a Mircera injection**
- ☐ **Safe sharps disposal**
- ☐ **Understanding prescription labels**
- ☐ **My medications**

NUTRITION

- ☐ **Getting started on the PD diet**
- ☐ **The PD plate method**
- ☐ **Diabetes and blood sugars**
- ☐ **Ready for a change?**
- ☐ **Disaster diet planning**

Eating Well on Peritoneal Dialysis (PD)
Foods you need to stay healthy

- ☐ **Potassium**
  - Why potassium is important
  - What foods are high in potassium
    - Potassium brochure
  - Signs and symptoms of a low potassium
    - What to do if you think you have a low potassium
  - Sick Day Foods brochure

- ☐ **Protein**
  - Why increasing protein is important
  - What foods are high in protein
    - Protein brochure

- ☐ **Sodium and fluid**
  - Why managing sodium and fluid intake are important
    - Sodium brochure
  - What foods are high in sodium, what alternatives are there
  - How to manage your thirst and fluid intake

- ☐ **Constipation**
  - Why are regular bowel movements important for PD

- ☐ **Communicating with your dietitian**
  - Business Card and contact information

LIVING WITH PD

- ☐ **Transportation for PD patients**
- ☐ **What your Social Worker can do for you**
- ☐ **Depression and your health**
- ☐ **Positive steps to well-being**

PREPARING FOR DISASTER

- ☐ **Surviving a disaster**
- ☐ **Dialysis Emergency 5 Day Meal Plan**
- ☐ **Disaster Planning—What to Have at Home**

CAPD Training Acknowledgement

Completion of signatures on this form certify that both the trainee(s) and the training nurse(s) believe trainee(s) are competent to perform CAPD.

Indications of competence required:

1. Demonstrate a safe CAPD exchange
2. Demonstrate recording vital signs and treatments
3. Respond safely when there is a problem with CAPD treatments
4. Verbalize how to get help for CAPD treatment problems

_____ Date _____
Patient

_____ _____ Date _____
Others trained Relationship

_____ _____ Date _____
Others trained Relationship

_____ Date _____
PD nurse

_____ Date _____
PD nurse

_____ Date _____
PD nurse

CAPD Training Quiz

Keeping Clean and Setting Up

1 Hand washing is the most important way to protect yourself from germs and help prevent infection.

True False

2 You should wash your hands before you do which of the following?

a. Do your exit-site care
b. Gather your supplies
c. Connect and disconnect from your PD exchange
d. All of the above

3 Good hand washing means you must do which of the following?

a. Use plenty of clean running water and liquid soap in a pump dispenser
b. Wash well between your fingers and underneath your nails
c. Rub your hands vigorously
d. Dry your hands completely with a disposable paper towel
e. All of the above

4 If you rub your eye after washing your hands, you should wash and dry your hands again or use hand sanitizer.

True False

5 To use hand sanitizer correctly, you should do which of the following?

a. Apply enough hand sanitizer to cover and clean both hands
b. Rub your hands together thoroughly
c. Use enough hand sanitizer to last for at least 20-30 seconds
d. All of the above

6 It is important that you do your PD treatment as you were trained to help keep germs from entering your peritoneal cavity.

True False

7 If you drop or touch the inside of the MiniCap disconnect cap, you should throw away the cap and start again with a new one.

True False

8 You should store your solution bags in an area without excessive heat or cold.

True False

9 You should do your PD exchanges in a clean room without distractions and give all attention to what you are doing.

True False

10 During the summer, you may leave the windows open or the fan on while you set up for your PD treatment.

True False

CAPD Training Quiz

Taking Care of Your Catheter and Exit Site

1 Antibiotic cream on the exit site helps to prevent infection.

True False

2 Before exit site care, it is important to look at your exit site and the area around it to make sure which of the following is not present?

a. Redness
b. Swelling
c. Drainage
d. All of the above

3 To check your catheter tunnel (area where the catheter is placed under the skin), feel along it with your fingers. It should not be tender or swollen.

True False

4 If crusts or scabs are present on your exit site, you should leave them in place until they fall off on their own.

True False

5 A healthy exit site should not have drainage.

True False

6 Which of the following are signs of an exit site infection?

a. Redness
b. Drainage
c. Tenderness
d. All of the above

7 Which of these may be signs and symptoms of peritonitis?

a. Stomach pain
b. Fever
c. Cloudy fluid
d. All of the above

8 You should report signs of redness, swelling or soreness at your exit site to your PD nurse, as directed.

True False

9 Which action should you take if there is a hole in your catheter?

a. Put a clamp on the catheter between the hole and yourself
b. Call your PD nurse immediately
c. Do not do any more exchanges
d. All of the above

10 If you feel sick, have a fever or stomach pain, or see cloudy fluid in your drain bag, you should call your PD nurse immediately.

True False

CAPD Training Quiz

Steps for a Safe Treatment

1 You should weigh yourself, take your blood pressure, and do a physical assessment before every PD treatment.

True False

2 Aseptic technique is used to keep germs from coming in contact with sterile supplies.

True False

3 If you touch the inside of the MiniCap disconnect cap, the cap is contaminated.

True False

4 Which of these are common areas of contamination?

a. Connection to UltraBag System
b. Ports on solution bags
c. Connection to your transfer set
d. All of the above

5 After you clean your work surface, it is sterile.

True False

6 Always wear a mask when you connect or disconnect from your transfer set.

True False

7 You need to check the PD solution bag before your treatment.

True False

8 After your PD treatment, empty all fluids from drainage bags and lines into your drainage area.

True False

9 What should you do if the tubing or catheter is kinked?

a. Place an UltraClamp tubing on the drain line
b. Close the transfer set clamp
c. Straighten out the tubing and the catheter

10 What should you do if the drained fluid is cloudy?

a. Call your PD nurse immediately
b. Tell your doctor at your next clinic visit
c. This is nothing to worry about

PD Training Quiz

Managing Fluids on Peritoneal Dialysis (PD)

1 Keeping your fluid in balance will help you prevent fluid overload and dehydration.

True False

2 Too much fluid can lead to swelling, high blood pressure, trouble breathing, and rapid weight gain.

True False

3 If you notice less urine output, tell your PD nurse, as directed.

True False

4 PD solution comes in just one strength.

True False

5 What should you do each day to check your fluid balance?

a. Weigh yourself and record it
b. Take your blood pressure and record it
c. If you use a cycler, record your ultrafiltration information
d. All of the above

6 In the morning, check for swelling around your eyes.

True False

7 If you have too much fluid (fluid overload) in your body, you should:

a. Consume less fluids
b. Limit salt (sodium) intake
c. Talk to your PD nurse about using a higher-strength PD solution
d. All of the above

8 If you have too little fluid in your body (dehydration), you should:

a. Consume more fluid
b. Talk to your PD nurse about using a lower-strength PD solution
c. Eat some salty foods
d. All of the above

9 When choosing PD fluids, a 1.5% dextrose solution will remove the least amount of fluid.

True False

10 What are some of the actions you should take if you have swelling or puffiness in your face, hands, lower legs, or ankles?

a. Check your weight and blood pressure
b. Check to make sure you are using the correct PD solution
c. Decrease your fluid and salt intake
d. All of the above

PD Training Quiz

Ordering Your Dialysis (PD) Supplies

1 What information is included in the booklet "Managing Your PD Supplies at Home"?

a. Ordering
b. Delivery
c. Storage
d. Waste Disposal
e. All of the above

2 Your dialysis unit will place your first supply order.

True False

3 How do you know when your delivery will arrive?

a. This information is on the delivery schedule from Baxter
b. An automated pre-delivery phone call from HomeCare Services will tell you this information
c. All of the above

4 Your mailman will deliver your supplies to the front door of your home.

True False

5 When your delivery arrives, use the packing list to check your supplies to be sure your delivery is correct.

True False

6 When your delivery arrives, what should you check your cases for?

a. Damage, including holes
b. Wrapping and sealing of sterile supplies
c. Expiration date has not passed
d. All of the above

7 Store your supplies in a clean, dry room that is away from pets, insects, rodents, and extreme heat or cold.

True False

8 Place the newest supplies in front of the older ones in your supply storage area.

True False

9 It is important to keep track of your supplies and dialysis solution.

True False

10 In which of the following situations should you call your PD nurse with questions about your supplies or equipment?

a. If your last delivery was short of supplies
b. If you need emergency supplies
c. If the ordered or delivered supplies or solutions were incorrect or not part of your order
d. All of the above

PD Training Quiz

Understanding Your Medications

1 Check with your doctor or PD nurse before taking any non-prescribed or over-the-counter medications.

True False

2 It is important to keep a list of all your medications, dosages, and any drug allergies with you at all times.

True False

3 Which of the following is true about iron?

a. Iron pills work best when taken on an empty stomach

b. Iron should not be taken with phosphate binders, antacids, or milk

c. If you get an upset stomach, check with your doctor or PD nurse for suggestions to relieve your symptoms

d. All of the above

4 Stool softeners help promote softer, easier bowel movements.

True False

5 Blood pressure medication works best when taken on the schedule your doctor has prescribed.

True False

6 To be most effective, phosphate binders should be taken at the same time as your meals or snacks.

True False

7 Vitamin D works with calcium in your body to keep your bones strong and healthy.

True False

8 Which of the following medications may be ordered by your physician to be added to your dialysis solution?

a. Insulin

b. Antibiotics

c. Heparin

d. All of the above

9 Which of the following is true about heparin?

a. Heparin may be used to maintain catheter flow when fibrin is present

b. Heparin helps your body make more red blood cells

c. Heparin helps maintain your blood sugar level

10 If your doctor has ordered antibiotics, you may stop taking them once you feel better.

True False

PD Training Quiz

Eating Well on Peritoneal Dialysis (PD)

1 Which of the following foods will help you do your best on PD?

a. Protein rich foods

b. Packaged and processed foods

c. Chicken noodle soup

2 Why is it important to eat a low sodium diet?

a. It tastes better

b. You like it more

c. It helps control blood pressure and thirst

3 Your diet may change based on your monthly lab results.

True False

4 Which of these groups are considered high potassium that you need to eat more?

a. Bread, noodles, rice

b. Bananas, oranges, tomatoes, avocados

c. Jell-O, soup, cranberry juice

5 Which is NOT a way to control phosphorous in your diet?

a. Taking binders with meals

b. Limiting to one serving of dairy each day

c. Avoiding processed and packaged foods

d. Enjoying bananas and tomatoes

6 How can you avoid weight gain on PD (choose more than one)?

a. Use the 1.5% dextrose (yellow) solution

b. Increase your exercise

c. Limit foods that are not high protein or potassium

d. Eat a high salt diet

Quiz Answer Key for RNs

Quiz Title	Answers
CAPD Keeping Clean and Setting Up	1-True, 2-d, 3-e, 4-True, 5-d, 6-True, 7-True, 8-True, 9-True, 10-False
CAPD Taking Care of Your Catheter and Exit Site	1-True, 2-d, 3-True, 4-True, 5-True, 6-d, 7-d, 8-True, 9-d, 10-True
CAPD Steps for a Safe Treatment	1-True, 2-True, 3-True, 4-d, 5-False, 6-True, 7-True, 8-True, 9-c, 10-a
Managing Fluids on Peritoneal Dialysis (PD)	1-True, 2-True, 3-True, 4-False, 5-d, 6-True, 7-d, 8-d, 9-True, 10-d
Ordering Your Peritoneal Dialysis Supplies	1-e, 2-True, 3-c, 4-False, 5-True, 6-d, 7-True, 8-False, 9-True, 10-d
Understanding Your Medications	1-True, 2-True, 3-d, 4-True, 5-True, 6-True, 7-True, 8-d, 9-a, 10-False
Eating Well on Peritoneal Dialysis (PD)	1-a, 2-c, 3-True, 4-b, 5-d, 6-a,b,c
APD Keeping Clean and Setting Up	1-True, 2-e, 3-True, 4-c, 5-True, 6-True, 7-b, 8-b, 9-e
APD Taking Care of Your Catheter and Exit Site	1-True, 2-e, 3-True, 4-c, 5-True, 6-True, 7-b, 8-b, 9-e
APD Steps for a Safe Treatment	1- b, 2-True, 3-d, 4-True, 5-e, 6-True, 7-True, 8-True, 9-a, 10-a