

This form must be sent to the NKC Admissions Office. Please do not send to / or contact individual departments.

MODALITY CHANGE REQUEST

Patient Name: _____ Preferred Facility or Patient
Zip Code: _____

Modality Change: Permanent Temporary < 30 days > 30 Days

Modality Type: PD Urgent Start ICPD HHD ICHD

HBs Ag positive: Yes No

Anticipated Modality Start Date: _____

CKD Modality Class Attended: ICHD PD HHD **Date:** _____

ICHD/HHD Access: AVF AVG CVC

PD Access: **PD Catheter** Date Externalized (if applicable): _____

Surgical Date: _____ **Surgeon:** _____

Patient Care Needs

- Chair Bed Bariatric Bed Stretcher/Ambulance Transport
- Patient can not ambulate 50 feet independently with or without assistive device
- Special Care Services
- Isolation Contact (MRSA; C diff) Other _____
- Patient is unable to give informed consent - family/DPOA name: _____
- Requires an interpreter - if yes, language: _____
- Patient has scheduling preferences due to: Work School Religion
Other: _____

Required Information *(Initial Orders must accompany this form)*

- Initial **PD** Orders *(within prior 30 days)* **or**
- Urgent Start** Orders *(within 30 days)* **or**
- Initial **ICPD** Orders *(within prior 30 days)* **or**
- Initial **HHD** Orders *(within prior 30 days)* **or**
- Initial **ICHD** Orders *(within prior 30 days)*
- Dialysis Access** Operative Report

Attending Nephrologist's Name:

Signature

Date

PHONE: 206-292-3090

FAX TO: 206-343-4124