



**ARKANSAS
NEPHROLOGY
SERVICES, LTD.**

Administrative Offices

1900 Malvern, Suite 304
Hot Springs, AR 71901
(501) 624-6000
Fax (501) 321-0710

Ouachita Regional Dialysis Center

1900 Malvern, Suite 102
Hot Springs, AR 71901
(501) 624-0196

Hot Springs Dialysis

One Mercy Lane, Suite 103
Hot Springs, AR 71913
(501) 624-0153

South Arkansas Kidney Center

308 ½ Cordell
El Dorado, AR 71730
(870) 862-8788

Ouachita Valley Kidney Center

1114 Washington, N.W.
Camden, AR 71701
(870) 246-3021

DeGray Kidney Center

312 Professional Park Dr., Suite H
Arkadelphia, AR 71923

River Valley Kidney Center

3121 West Second Court
Russellville, AR 72801
(501) 968-4687

Ashley Kidney Center

1019 Fred LaGrone Drive
Crossett, AR 71635
(870) 305-1225

Malvern Kidney Center

1580 Tanner Rd.
Malvern, AR 72104
(870) 332-3000

Dear Transient Patient Coordinator,

Thank you for your inquiry about an Arkansas Nephrology Services, Ltd. dialysis facility.

Enclosed you will find a packet of information. Please return the completed forms and the patient's records as soon as possible.

As you know, space is a consideration. Space is reserved for visitors as the completed packets are received.

It is necessary to have all requested information and lab values (including the HBSAg and HIV results) before we can present the patient's chart to an ANS physician for review. It is ANS policy that all dialysis patients be screened for infectious disease prior to treatment.

When we have received all requested information, you will be notified if we are able to accommodate your patient. Information must be received at least seven (7) days prior to treatment date.

Should you have any questions, please feel free to call the business office at (501) 321-9803.

Sincerely,

Penny Schoggin, R.N., C.N.N.
Transient Coordinator

ARKANSAS NEPHROLOGY SERVICES, LTD.

TRANSIENT DEMOGRAPHIC DATA

Patient Name: _____ Sex: _____ DOB: _____

Address: _____ Marital Status: _____

City: _____ State: _____ ZIP: _____

Home Phone: () _____

Contact person at "home" dialysis unit: _____

Local address where staying: _____

Local phone number: () _____ Purpose: _____

Dates requested for dialysis: _____

ANS dialysis unit requested: _____

Ouachita Regional Dialysis Center – Hot Springs
DeGray Kidney Center – Arkadelphia
South Arkansas Kidney Center – El Dorado
Ashley Kidney Center – Crossett

Hot Springs Dialysis – Hot Springs
River Valley Kidney Center – Russellville
Ouachita Valley Kidney Center – Camden
Malvern Kidney Center – Malvern

Please specify primary and secondary insurance coverage:

Primary: _____ Policy #: _____

Address: _____ Phone #: _____

Secondary: _____ Policy #: _____

Address: _____ Phone #: _____

In case of an emergency please notify: _____

Phone: _____

MEDICAL INFORMATION:

Cause of ESRD: _____ ESRD Date: _____

Transplant Candidate: YES or NO

MEDICAL INFORMATION CONTINUED:

Home Medications: _____

Diet: _____

Allergies: _____

Referring Physician: _____ Phone: () _____

Address: _____

Billing Contact Information: _____

DIALYSIS INFORMATION:

1. Dialyzer size in square meters (m²) (not brand name): _____

Reuse: YES or NO If no, please explain: _____

2. How many hours/times per week does patient dialyze? _____

3. Dialysate: _____

4. Blood Flow: _____

5. Dry weight in kilograms (kg): _____

6. Heparin dose – loading: _____ Units per hour: _____

7. Usual interdialytic weight gain: _____

8. Usual pressure – Arterial: _____ Venous: _____

9. Please describe access site and illustrate on enclosed diagram. _____

10. Needle Size: _____

DIALYSIS INFORMATION CONTINUED:

11. Dialysis Medications – EPO: _____ Calcijex: _____
Infed: _____ Other: _____

12. Interdialytic Problems: _____

13. Most recent URR: _____

ENCLOSURES:

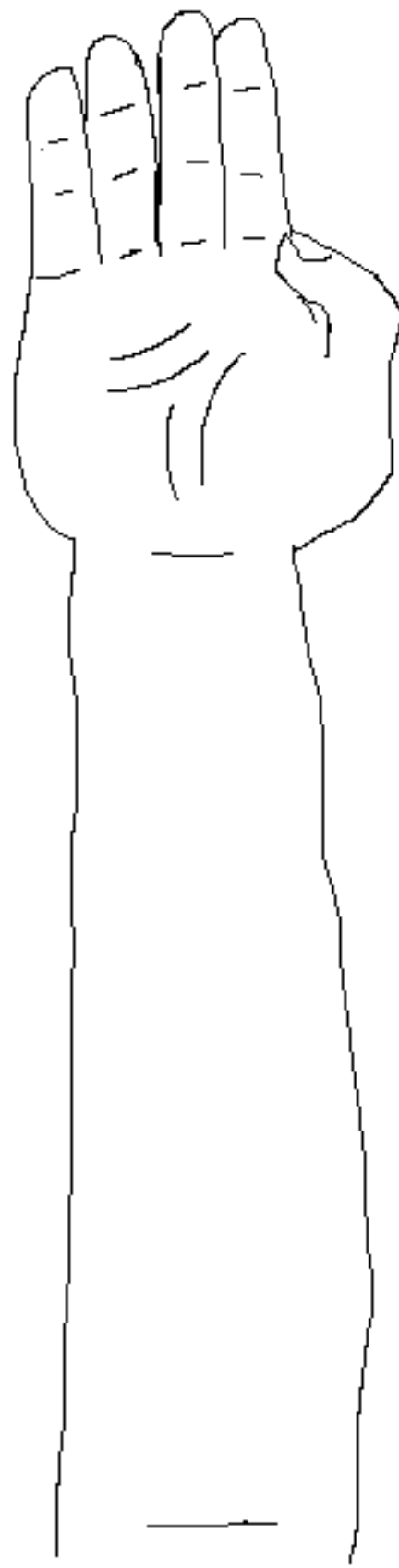
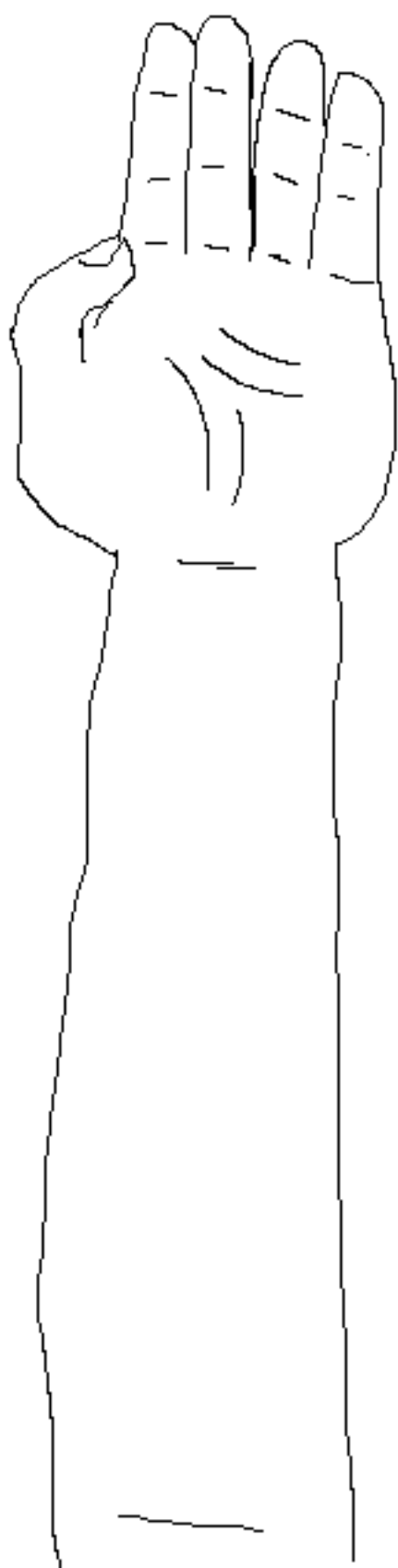
Please enclose **all** of the following information:

- _____ Last available chest x-ray report
- _____ Last three dialysis treatment log sheets
- _____ Nursing care plan
- _____ HBSAg (within 30 days of planned treatment)
- _____ HIV (within 30 days of planned treatment)
- _____ Last available EKG report
- _____ Medication record (home meds, routine and prn)
- _____ Current History and Physical
- _____ Release of information form
- _____ Copy of most recent comprehensive lab report
- _____ Copy of insurance cards (front and back)
- _____ Copy of 2728

ALL OF THE ABOVE INFORMATION MUST BE INCLUDED IN ORDER TO CONFIRM DIALYSIS DATES REQUESTED.

THIS INFORMATION IS NOT USED TO DETERMINE ELIGIBILITY, IT IS USED TO ENABLE OUR PHYSICIANS TO BETTER CARE FOR THE DIALYSIS PATIENT IN THE EVENT COMPLICATIONS SHOULD ARISE.

PATIENT: _____ TYPE OF ACCESS: _____



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Malvern, Arkansas

Assignment of Medicare Benefits

I, _____, authorize the above named facility to release any information which may be necessary to determine Medicare benefits payable, and request that payment under the Medicare program be made to the facility for any services furnished by that provider.

Patient's signature

Date

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Patient's Name: _____

Date: _____

I have been informed that I have a medical condition termed "chronic renal failure" and repetitive hemodialysis for the treatment of this condition has been explained to me. The inherent and potential risks of the treatment, its discomforts, complications, and other consequences, as well as its benefits, have been explained to my satisfaction.

I hereby authorize, and without influence or duress, give my full consent to Arkansas Nephrology Services, Ltd., the above named facility, and under the direction of its staff, physicians, associates and assistants, to administer repetitive hemodialysis to me. I acknowledge and understand that artificial kidney treatments are life-sustaining procedures, but they are not a cure for kidney failure. No promise or guarantee has been made to me concerning the result of these treatments. I agree to hold without blame Arkansas Nephrology Services, Ltd., its facilities, physicians, associates and assistants from any liability or ill effects to me, which result from the natural course of chronic renal failure and repetitive hemodialysis.

I understand that the artificial kidneys used for my dialysis treatments conducted at this unit will be used more than once unless medically contra-indicated, although they will be used only for my treatments. The multiple use of the dialyzer has been explained to me.

I certify that I have read and fully understand the above consent.

Patient: _____ Witness: _____

I certify that the patient has been informed of the nature, risks, and possible results of chronic renal failure and repetitive hemodialysis, and multiple use of the dialyzer.

Signature of Physician