NORTHWEST Kidney Centers

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

Diagnosis ICD-10 Code: ☐ ESRD_____ ☐ **HBs Ag positive:** ☐ Yes ☐ No

Anticipated Modality Start Date: ☐ 1-10 days ☐ 10-30 days ☐ ≥ 30 days

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

V7/31/2017