



NAME _____
Network: ESRD Network 18 Toll-Free #: (800) 637-4767

I AM A DIALYSIS PATIENT.

VITAL INFORMATION

MEDICATIONS

Medication	Dose	Frequency
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_____	_____	_____
_____	_____	_____
_____	_____	_____

Pharmacy & Phone: _____

Special Needs: _____

Diagnosis: _____

Allergies: _____

PERSONAL INFORMATION

Address: _____

Phone: () _____

Cell Phone: () _____

Emergency Contact: _____

Relation: _____

Emergency Phone: () _____

Nephrologist: _____

Nephrologist Phone: () _____

DIALYSIS PRESCRIPTION

_____ Hours _____ X / Week

_____ Dialyzer

_____ Dialysate

Other Insurance: _____

Medicare #: _____

Medicaid #: _____

DIALYSIS UNIT

Provider Name: _____

Phone: () _____