

# Admissions Intake Form

To facilitate timely placement, please submit this intake form in full.

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Admission Type:    New Admission    Resume (*within 30 days*)    Readmission (*post 30 days*)    Transfer-in Non-DaVita

## About You

Your Name: \_\_\_\_\_ Contact Phone: \_\_\_\_\_  
Your Title: \_\_\_\_\_ Contact Fax: \_\_\_\_\_  
Hospital/Practice: \_\_\_\_\_ Contact Email: \_\_\_\_\_

Mark Preferred  
Contact Method

## COVID-19 Screening

Has the patient tested positive for COVID-19 within the last 10 days?    Yes    No

## Patient Information

Patient Name: \_\_\_\_\_  
Nephrologist: \_\_\_\_\_ Special Needs: \_\_\_\_\_

Does the patient:	Yes	No	Documents Attached	Page#	Access Type	Diagnosis
Currently have a trach?				_____	CVC	ESRD
Have a history of trach?				_____	Fistula	AKI
Require treatment in a bed?				_____	Other: _____	

Does the patient currently have any reportable communicable diseases?  
Please select:    Candida Auris    CRE    None

First Date of Dialysis Ever: \_\_\_\_\_  
In-center Hemo    Home Hemo    PD

## Patient Scheduling

Anticipated Discharge Date: \_\_\_\_\_  
Preferred Facility(s) or Zip Code: \_\_\_\_\_  
Treatment Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

Is the patient interested in home dialysis?    Yes    No    Not Yet Discussed

Schedule Preference:  
MWF    a.m.  
TTS    p.m.

Is the patient:    Yes    No  
Flexible with facility?  
Flexible with shift?  
Employed?  
Able to sign consents?

## Attached Clinical Documents

Face Sheet (*with insurance and demographics*)  
PPD or Chest X-Ray (*with 90 days*) PPD Preferred  
History and Physical (*within last year*)

**Hepatitis (Hep) B Panel**  
- HEP B Surface Antigen (HBsAg) (*within 30 days*)  
- HEP B Surface Antibody (HBsAb) (*within 12 months*)  
- HEP B Total Core Anitbody (HBcAb) (*within 12 months*)

Submission of this form without the full Hep B, but with HBsAg at a minimum, constitutes a request for emergency admission.

PHONE: 1-866-475-7757 | FAX: 1-866-720-0766  
ONLINE: [ADMIT.DAVITA.COM](https://admit.davita.com)

