**Reason for Assessment**  (Complete for each Assessment)

<table>
<thead>
<tr>
<th>R1: State Reason for Assessment</th>
<th>Initial</th>
<th>90 Days</th>
<th>Monthly (Unstable)</th>
<th>Annual (Stable)</th>
</tr>
</thead>
</table>

**R1a: Patient is unstable if he/she has any of the following (select all that apply):**

- **Frequent Hospitalization**
  - More than three hospitalizations in one month or extended hospitalization longer than 8 days or new substantial change in condition resulting in significant changes in medical/functional status

- **Poor Nutritional Status**
  - Includes failure to thrive symptoms, with loss of body weight or poor growth with low serum albumin

- **Unmanaged Anemia**
  - Includes continued lab findings of Hgb/Hct <10 g/dL or >13.0 g/dL, Ferritin >100 mg/mL <500 mg/mL, Transferrin Saturation <20%

- **Significant Change in Psychosocial Needs**
  - Includes instability in one’s own or immediate family member’s employment, physical or emotional abuse, deterioration in mental or functional status, housing instability, death or major illness in the family, and loss of emotional support

- **Inadequate dialysis**
  - Include findings of Kt/V or URR which do not meet minimum expectations for age

- **New Substantial Change in Condition**
  - A recurrent serious complication while undergoing dialysis (severe hypotension, seizures, dysrhythmia, dialysis access issues resulting in freq. interventions/changes to dialysis orders to achieve adequate dialysis)

- **Other:**

---

**Demographics**  (Complete only for Initial and Annual Assessment)

<table>
<thead>
<tr>
<th>Complete by RN/MD – Completed by</th>
<th>Date: / /</th>
<th>Time: AM/PM</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Birth:</th>
<th>/ /</th>
<th>Age at Assessment:</th>
<th>Yr</th>
<th>Months</th>
<th>Gender:</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Race/Ethnicity:</th>
<th>American Indian/Alaska Native</th>
<th>Asian</th>
<th>Black /African American</th>
<th>Hispanic/Latino origin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Native Hawaiian or Pacific Islander</td>
<td>White</td>
<td>Unknown</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Primary Pediatrician: | | |
|----------------------| | |
| Dentist: | | |

<table>
<thead>
<tr>
<th>Date of First Dialysis:</th>
<th>/ /</th>
<th>(located on 2728)</th>
</tr>
</thead>
</table>

| Date of first Treatment at Facility: | / / | |
|-------------------------------------|-----| |
Medical History (Complete for Initial and Annual Assessment)
Complete by RN/MD – Completed by Date: / / 

<table>
<thead>
<tr>
<th>History</th>
<th>Negative</th>
<th>Diagnoses</th>
<th>Explanations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cardiovascular</td>
<td></td>
<td>Hypertension, Left ventricular hypertrophy, Congenital heart defect, Cardiomyopathy, Pericarditis</td>
<td>Dyslipemia, Pericardial effusion, Heart transplant, Other</td>
</tr>
<tr>
<td>2. Pulmonary</td>
<td></td>
<td>Asthma, Sleep Apnea, Chronic lung disease (Pulmonary hypoplasia, BPD), Tracheostomy, Tuberculosis (TB)</td>
<td>Chronic Tobacco Use, Other</td>
</tr>
<tr>
<td>3. Endocrine</td>
<td></td>
<td>Secondary hyperparathyroidism, Parathyroidectomy, Hypothyroidism, Hyperthyroidism, Growth failure, Vitamin D deficiency</td>
<td>Other, Diabetes mellitus: Type I, Type II, Diet-controlled, Insulin-controlled, Self-monitoring</td>
</tr>
<tr>
<td>4. Gastrointestinal Disorders</td>
<td></td>
<td>GI Bleeding, Gastro esophageal reflux, Failure to thrive, Pancreatitis, Oxalosis</td>
<td>Liver disease or transplant, Chronic Bowel Diseases (Crohns/Hurshprung/IBS), Portal Hypertension, Other</td>
</tr>
<tr>
<td>5. Neurological Disorders</td>
<td></td>
<td>Seizure disorder, Spina Bifida, Hydrocephalus</td>
<td>CP/Developmental Delay, Other</td>
</tr>
<tr>
<td>6. Musculoskeletal</td>
<td></td>
<td>Renal osteodystrophy, Rickets, Scoliosis, Osteoporosis, JRA, Hip Dysplasia</td>
<td>History of Fractures, Morbid Obesity, Prune Belly (Triad Syndrome), Other</td>
</tr>
<tr>
<td>8. Immune</td>
<td></td>
<td>Systemic Lupus Erythematosus, Vasculitis</td>
<td>Other</td>
</tr>
</tbody>
</table>

Explanations:
9. Infection
   - Hepatitis A
   - Hepatitis B
   - Hepatitis C
   - HIV / AIDS
   - Urinary Tract Infections
   - TB
   - History of MRSA/VRE (Drug resistant bacterial infections)
   - Other

   Explanations:

10. Hematologic Conditions
   - Sickle cell disease
   - Bleeding/Clotting disorder
   - Anemia – Treatment with ESA (erythropoietin)
   - Iron deficiency – Treatment with PO Iron Treatment with IV Iron
   - Prior transfusions: # _______
   - Prior transfusions reactions
   - Other

   Explanations:

11. Head Ears Eyes Nose Throat (HEENT)
   - Impaired vision
   - Hearing loss
   - Poor dentition
   - Retinopathy
   - Frequent ear infections/sinusitis
   - Other

   Explanations:

12. Malignancy
   - Explanations:

13. Psychiatric
   - Bipolar
   - Suicide attempts
   - Self injury (cutting)
   - Schizophrenia
   - Borderline Personality
   - OCD
   - Drug/ETOH Dependency
   - Other

   Explanations:

14. Surgical History
   - List procedures:

**Health Status Changes** (Complete only when the patient has developed new conditions since last assessment)

<table>
<thead>
<tr>
<th>Date</th>
<th>Health Status Change added to Medical History</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Patient Systems Review** (Complete for all Assessment)

<table>
<thead>
<tr>
<th>System</th>
<th>Normal</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Access:</td>
<td>AVF</td>
<td>PD</td>
</tr>
<tr>
<td></td>
<td>AVG</td>
<td>Access Location:</td>
</tr>
<tr>
<td></td>
<td>PC</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Routine health screenings:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Annual Well Child Exam Date: / /</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dental exam Date: / /</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eye exam Date: / /</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. General Health:</td>
<td>Fatigue</td>
<td>Ecchymoses</td>
</tr>
<tr>
<td></td>
<td>Weight Loss</td>
<td>Petechia</td>
</tr>
<tr>
<td></td>
<td>Night Sweats</td>
<td>Alopecia</td>
</tr>
<tr>
<td></td>
<td>Weight Gain</td>
<td>Edema-Location:</td>
</tr>
<tr>
<td></td>
<td>Sleep Loss</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fever</td>
<td></td>
</tr>
<tr>
<td>3. Skin:</td>
<td>Pruritis</td>
<td>Nystagmus</td>
</tr>
<tr>
<td></td>
<td>Rash</td>
<td>Dry</td>
</tr>
<tr>
<td></td>
<td>Lesions</td>
<td>Cataracts</td>
</tr>
<tr>
<td></td>
<td>Pain</td>
<td>Fundoscopic Changes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Eyes:</td>
<td>Discharge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diplopia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conjunctivitis</td>
<td></td>
</tr>
</tbody>
</table>
| 5. Ears: | □ | Otitis Media  
□ Tinnitus  
□ Hearing Deficit  
□ Pain  
□ Drainage |
| 6. Nose: | □ | Discharge  
□ Epistaxis  
□ Rhinorrhea |
| 7. Mouth: | □ | Gingival Hyperplasia  
□ Bleeding Gums  
□ Poor Dentition |
| 8. Neck: | □ | Sore Throat  
□ JVD  
□ Thyromegaly  
□ LAD  
□ Trachea Midline |
| 9. Heart: | □ | Murmur  
□ Tachycardia  
□ Bradycardia  
□ Chest Pain  
□ Irregular Beat  
□ Edema-Location: |
| 10. Resp: | □ | SOB  
□ Cough, Productive  
□ Cough, Dry  
□ Wheeze  
□ Decreased Breath Sounds  
□ Rales  
□ Rhonchi  
□ TB Exposure |
| 11. GI: | □ | Nausea  
□ Vomiting  
□ Diarrhea  
□ Constipation  
□ Indigestion  
□ Poor Appetite |
| 12. GU: | □ | Residual Urine Output /Day  
□ Intermittent Straight Cath /day)  
□ Toilet Trained  
□ Dysuria  
□ Frequency  
□ Urgency  
□ Hematuria  
□ Nocturia  
□ Urinary Retention  
□ Flank Pain  
□ Hydrocele |
| 13. MS: | □ | Joint Pains  
□ Myalgia  
□ Gout  
□ Joint Swelling  
□ Cramps  
□ Exercise Intolerance |
| 14. Heme: | □ | Anemia  
□ Ecchymosis  
□ Thrombocytopenia  
□ Bleeding Disorder |
| 15. Immune: | □ | Frequent Infections |
| 16. Endocrine: | □ | Poor Growth  
□ Poor Diabetes Control  
□ Heat/Cold Intolerance |
| 17. Reproductive: | □ | Sexually Active  
Female:  
□ Breast Pain  
□ Breast Discharge  
□ Breast Lump  
□ Tanner Stage:  
□ First Menses:  
□ LMP /  
□ Menstrual Issues:  
Male:  
□ Testicular Pain  
□ Hernia  
□ Tanner Stage: |
18. Neuro:
- Seizure
- Tremor
- Reflexes
- Syncope
- Memory Problems
- Cranial Nerves
- Sensory Deficits

19. Psych:
- Anxiety
- Depression
- Anhedonia
- Substance Abuse
- Mood Swings

**What kinds of things make your pain feel better? (Heat, Meds, rest)**

**What kinds of things make your pain worse? (Walking, Standing, Lifting)**

**What treatments or medications are you receiving for pain?**

<table>
<thead>
<tr>
<th>Number that best describes your pain on the <strong>AVERAGE</strong>?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>No Pain</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number that best describes your pain at its <strong>LEAST</strong> in the past week?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>No Pain</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number that best describes your pain at its <strong>WORST</strong> in the past week?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
<tr>
<td>No Pain</td>
</tr>
</tbody>
</table>

**In the last week, how much relief have pain treatment or medications provided? Please circle the one percentage that most show how much relief you have received.**

<table>
<thead>
<tr>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
<th>60%</th>
<th>70%</th>
<th>80%</th>
<th>90%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Relief</td>
<td>Complete Relief</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Refer to pain clinic: □ No □ Yes

---

**Medication Review** (Complete for all Assessments)

**Complete by RN/MD – Completed by Date: / /**

- □ Medications reviewed
- □ Medication list updated
- □ Allergies reviewed
- □ Allergies updated
Immunization Review (Complete for all Assessments)
Complete by RN/MD – Completed by Date: / / 

Childhood Immunizations
☐ Up to date
☐ Needs: 
List immunizations needed:
☐ Not a candidate or refuses

Hepatitis B antibody
☐ Immune
☐ Not Immune
☐ Nonresponder

Hepatitis B
☐ Series in Progress:
  ☐ 1st ☐ 2nd ☐ 3rd
☐ Needs
☐ Not a candidate or refuses

Hepatitis A
☐ Series in Progress:
  ☐ 1st ☐ 2nd
☐ Needs
☐ Not a candidate or refuses

Influenza
☐ Date given:
☐ Needs

Pneumococcal
☐ Pneumovax
☐ Prevnar
☐ Needs
☐ Refuses

Tuberculosis Screening
☐ No
☐ Yes, Date / /
☐ Positive
☐ Negative Initial

Laboratory Profile Review (Complete for all Assessment)
Complete by RN/MD – Completed by Date: / / 

☐ Lab results reviewed
Note significant abnormalities:

Evaluation of Disease Knowledge (Complete for Initial and Annual Assessment)
Complete by RN/MD – Completed by Date: / / 

1. On the following items, indicate the patient’s level of understanding:
   Chronic Kidney Disease ☐ No Understanding ☐ Limited ☐ Adequate ☐ Excellent
   Treatment Options ☐ No Understanding ☐ Limited ☐ Adequate ☐ Excellent
   Dialysis Vascular Access Options ☐ No Understanding ☐ Limited ☐ Adequate ☐ Excellent

2. Patient participated in a pre-dialysis education program or session?
   ☐ Yes, location: ☐ No, reason:

Evaluation of Self-Management & Level of Participation in Care (Complete for all Assessments)
Complete by RN/MD – Completed by Date: / / 

1. How easy or difficult has it been for you to do the following:
   Easy Somewhat Easy Neither Easy nor Difficult Somewhat Difficult Difficult
   Come to each hemodialysis treatment: ☐ ☐ ☐ ☐ ☐
   Complete the full hemodialysis treatment time: ☐ ☐ ☐ ☐ ☐
   Perform every peritoneal dialysis treatment: ☐ ☐ ☐ ☐ ☐
   Take medications as prescribed: ☐ ☐ ☐ ☐ ☐
   Follow fluid restrictions: ☐ ☐ ☐ ☐ ☐
   Follow dietary restrictions: ☐ ☐ ☐ ☐ ☐
2. Patient assists with dialysis treatments (setting up machine, needles, catheter care):
   - [ ] Yes
   - [ ] No
   - [ ] Not Permitted in Facility

3. Number of treatments missed in the last 30 days: _____ treatments

4. Number of shortened treatments in the last 30 days: _____ treatments

5. Patients responsibility level for following their medication schedule:
   - [ ] Independent
   - [ ] Relies on parent/guardian

6. Patient demonstrates comfort asking staff/physician questions:
   - [ ] Yes
   - [ ] No
   If No Why:
   - [ ] Does not know what questions to ask
   - [ ] Cannot speak
   - [ ] Thinks asking questions is disrespectful
   - [ ] Cognition
   - [ ] Does not speak English or any language staff speaks
   - [ ] Other:

---

**Evaluation of Dialysis Prescription and Adequacy (Complete for all Assessment)**

Complete by RN/MD – Completed by: Date: / / 

1. Dialysis modality:
   - [ ] In-center Hemodialysis
   - [ ] Home Hemodialysis
   - [ ] Home peritoneal dialysis

2. Suitability for home dialysis:
   - [ ] Currently receiving home dialysis
   - [ ] Planning to start home dialysis on / / 
   - [ ] Unsuitable for home dialysis because:

3. Dialysis prescription:
   - Hemodialysis: Time: Hours
   - Liters Processed: Liters
   - Days/week
   - Dialyzer:
     - Qb ml/min
     - Qd ml/min
   - Dialysate:K: mEq/L
   - Ca**: mg/L
   - Bicarbonate: mEq/L
   - Temperature: °C
   - Peritoneal dialysis:
Time Hours
Fill volume: mL
Last fill volume: mL
Cycles:
Dwell time min
Solution:
% Dextrose
Calcium: mg/L

4. Dialysis Adequacy
HD Adequacy meeting target (Kt/v goal > 1.2, URR goal > 68%):
☐ Yes
☐ No
If No, why: ☐ Time/Liters Processed/Poor BFR related ☐ Access related ☐ Dialyzer related ☐ Missed treatments
☐ Other:

PD Adequacy meeting target (Kt/V goal >1.7):
☐ Yes
☐ No

PD PET Results:
☐ Low
☐ Low Average
☐ High Average
☐ High
If No, why: ☐ Time/Volume related ☐ Access related ☐ Peritoneum related ☐ Missed treatments
☐ Other:

Evaluation of Fluid Management/Blood Pressure (Complete for all Assessment)
Complete by RN/MD – Completed by Date: / /

1. Blood Pressure in range for age, gender and height (goal BP ):
☐ Yes ☐ No
Current number of BP medication:

2. Target Weight (Estimated Dry Weight) : Kg
Target Weight achieved post dialysis:
☐ At least 85% of treatments/month
☐ 85%-50% of treatments/month
☐ Less than 50% of treatments/month

Blood Volume monitor show refill:
☐ Yes ☐ No
Intradialytic weight gain:
☐ Acceptable
☐ Unacceptable (high)
☐ Unacceptable (low)

3. Intradialytic symptoms:
☐ Cramping ☐ Nausea
☐ Hypertension ☐ Hypotension
☐ Dizziness ☐ Hypoxemia
☐ Chest Pain ☐ Irritability
☐ Headache

Frequency of symptoms:
☐ Less than once a week
☐ Greater than once a week
☐ Almost every treatment

4. Estimated Residual Urine Output:
☐ Oligo/anuric
☐ Normal
☐ Polyuric

Evaluation of Anemia Management (Complete for all Assessment)
### Complete by RN/MD – Completed by       Date:       /      /

1. **Hgb 10-12 g/dL**
   - Hgb: ___ g/dL
   - Retic: __%  
   - Hct: __%  
   - WBC: ___ K/uL
   - ESA (Erythropoiesis Stimulating Agent) medication: ___ ESA dose: _____
   - Date of last ESA change: ___ / ___ / ___

2. **Ferritin: ___ ng/mL  Tsat: __%  Iron: ___ ug/dL  TIBC: ___ ug/dL**
   - Iron replacement medication: __
   - Iron dose: ___
   - Date of last iron dose change: ___ / ___ / ___

3. Co-morbid conditions affecting anemia:
   - □ infection/inflammation
   - □ hyperparathyroidism
   - □ other

4. Other factors affecting anemia:
   - □ Recent transfusions
   - Date of last transfusion: ___ / ___ / ___
   - □ Predisposition to bleeding
   - □ Occult blood tested

### Evaluation of Dialysis Access (Complete for all Assessment)

完整 by RN/MD – Completed by       Date:       /      /

1. **Hemodialysis**
   - Type of access: □ AVF  □ AVG  □ Catheter (go to # 8)
   - Location: __ Date placed: ___ / ___ / ___
   - Previous access history:

2. **Fistula/Graft Characteristics**
   - Average Blood Flow Rate (BFR): ___ mL/min
   - Average arterial pressure: ___ mm/Hg
   - Average venous pressure: ___ mm/Hg
   - Description: □ Straight  □ Curved  □ Loop tortuous  □ Aneurysms

3. **Cannulation method:**
   - □ Buttonhole  □ Rotation

4. **Preparation to limit pain with needle insertion:** □ Yes  □ No
   - □ Lidocaine  □ Lidocaine patch  □ Emla cream
   - □ Emla patch  □ Ethyl chloride spray  □ Other:

5. **Anticoagulation for Access:**
   - □ Yes  □ No
6. History of access infection:
   - Yes
   - No
   If yes, organism:
     - Staph aureus
     - Staph aureus methicillin resistant (MRSA)
     - Staph epi
     - Staph epi methicillin resistant E. coli
     - Enterococcus
     - Enterococcus vancomycin resistant (VRE)
     - Pseudomonas
     - Other:
   Treatment:  
     - Gentamicin
     - Vancomycin
     - Cefazolin
     - Clindamycin
     - Linezolid
   Date of last antibiotics: / /

7. Access Surveillance Method
   Physical finding:
     - Persistent swelling
     - Collateral veins
     - Prolonged bleeding
     - Altered pulse or thrill
   Intra-access flow
   Ultrasound: Results
   Recirculation
   Interventions required:  
     - Yes
     - No
   Angioplasty
     - Date: / /
   Surgical Revision
     - Date: / /
   Declotting procedures
     - Date: / /

8. Central Venous Catheter
   - Permanent Catheter
   - Temporary Catheter
   Date placed: / /
   Location:
   Catheter Function:
     - Achieving adequate flow
     - Unable to achieve adequate flow
     - Reversing lines to achieve flow
   Treatment for dysfunction:
     - Thrombolytic agent:
       - Alteplase tPA
       - Urokinase
     - Manipulation or replacement
       - Date: / /
   Exit Site:
   History of infection:
     - Yes
     - No
   If yes, organism:
     - Staph aureus
     - Staph aureus methicillin resistant (MRSA)
     - Staph epi
     - Staph epi methicillin resistant E. coli
     - Enterococcus
     - Enterococcus vancomycin resistant (VRE)
     - Pseudomonas
     - Other:
   Treatment:  
     - Gentamicin
     - Vancomycin
     - Cefazolin
     - Clindamycin
     - Linezolid
   Date of last antibiotics: / /
9. Peritoneal Dialysis Catheter:
   - □ Straight
   - □ Coiled
   - □ Swan neck
   - Date placed:   /   /

   Catheter function:
   - □ Patent
   - □ Migration
   - □ Repositioned/replaced

   History of infection:
   - □ Yes
   - □ No
   - □ Exit Site (if yes)
     □ Peritonitis
     - If yes, organism
       - □ Staph aureus
       - □ Staph aureus methicillin resistant (MRSA)
       - □ Staph epi
       - □ Staph epi methicillin resistant E. coli
       - □ Enterococcus
       - □ Enterococcus vancomycin resistant (VRE)
       - □ Pseudomonas
       - □ Other:

   Treatment:
   - □ Gentamicin
   - □ Vancomycin
   - □ Cefazolin
   - □ Clindamycin
   - □ Linezolid
   - Date of last antibiotics:   /   /

10. Catheter Exit Site Care:
    - □ Soap and water
    - □ Chloraprep
    - □ Betadine

    Antibiotic cream used:
    - □ Yes
    - □ No

    Exit site status:
    - □ Well healed
    - □ Red
    - □ Drainage
    - □ Swelling

    Cuff status:
    - □ Intact
    - □ Exposed

**Evaluation of Bone Disease Management** (Complete for all Assessment)

**Complete by RN/MD/RD – Completed by Date:**   /   /

1. Calcium in range for age (goal mg/dl):
   - □ Yes
   - □ No
   - Calcium mg/dl
   - Trends: □ Usually in Goal □ Usually High □ Usually Low □ Other:

2. Phosphorus in range for age (goal mg/dl):
   - □ Yes
   - □ No
   - Phosphorus mg/dl
   - Trends: □ Usually in Goal □ Usually High □ Usually Low □ Other:

3. Intact PTH 150-300 ng/ml:
   - □ Yes
   - □ No
   - I PTH mg/dl
   - Trends: □ Usually in Goal □ Usually High □ Usually Low □ Other:

4. Calcium x Phosphorus Product in range for age (goal mg2/dl2):
   - □ Yes
   - □ No
   - Product mg2/dl2
   - Trends: □ Usually in Goal □ Usually High □ Usually Low □ Other:
5. Medications:
- Phosphate Binders Adherence: □ Good □ Fair □ Poor
- Vitamin D Adherence: □ Good □ Fair □ Poor
- Calcium Supplements Adherence: □ Good □ Fair □ Poor

6. Diet Issues:
- Adherence □ Good □ Fair □ Poor

7. Education:
- Understands diet: □ Yes □ No □ Comments:

---

**Nutritional Assessment (Complete for all Assessment)**

**Complete by Dietitian – Completed by Date: / /**

1. **Anthropometrics:**
   - **Height or Length:** cm / In
   - **Height/length for age percentile:** 5% 10% 25% 50% 75% 90% >95%
   - **Weight:** kg / lb
   - **Weight for age percentile:** 5% 10% 25% 50% 75% 90% >95%
   - **Growth changes:**
     - 6-month weight velocity:
     - 6-month Height velocity:
   - **TSF:** %
   - **MAC:** %
   - **BMI for age percentile:** 5% 10% 25% 50% 75% 90% >95%
   - **Weight for length percentile:**
   - **Estimated Dry Weight:** kg / lb
   - **IDWG (Intradialytic Wt gain):** kg
   - **Growth Hormone:** □ Yes □ No □ Not a Candidate

2. **Nutritional Needs**
   - **Caloric Needs:** cal/kg (EDW)
   - **Protein Needs:** gm/kg (IBW)
   - **Fluid Needs:** ml/kg (BW)
   - **Nutrition Supplements:** □ No □ Yes, Type
   - **Formula provides:**
     - Kcal, g of protein, mL of fluid
   - **Nutrient delivery:** □ Tube Feeding □ Oral □ Other
   - **Feeding schedule:**
   - **Vitamins/Supplements:**

3. **Objective Data**
   - **Albumin (goal g/DL):** g/DL
   - **nPCR (goal ):**
   - **CO2 (goal mMol/L):** mMol/L

4. **Related Factors to Diet:**
   - **Appetite and intake:** □ Improved □ Decreasing □ Good □ Fair □ Poor
   - **Dietary intake adequate?** □ Yes □ No □ Excessive intake
   - **Fluid Control (Goal: Fluid gain <= 5% of EDW):** □ Goal met □ Goal not met
   - **Gastrointestinal changes lasting > 2 wks?** □ Yes □ No □ If “Yes”: □ Loss of appetite □ Nausea □ Vomiting □ Diarrhea
   - **Attitude to nutrition, health, and well-being:**
   - **Motivation to make changes to meet nutrition goals:**
   - **Other:**
5. Clinical Observations:
Muscle wasting Areas Severity
Edema Areas □+1 □+2 □+3 □+4
Subcutaneous Fat Depletion: Areas Severity
Patient is: □Well nourished OR At risk for malnourishment: □Mild □Moderate □Severe

6. Cultural Factors related to diet:
Religious food:
Cultural foods:
Person(s) responsible for food prep: □Patient □Guardian □Parent □Other
Primary language: □English □Spanish □Other:
Frequency for dining out: □Yes □No Number of Meals/Week:
Does patient receive food assistance? □No □Yes
If yes source:

Social Service Assessment
Complete by Social Worker – Completed by Date: / /

1. Advance Directives
□Yes, Copy in chart □Appointee Name:
□No
□Not Applicable due to patient’s age

□Do Not Resuscitate order at Facility □No □Yes
□Do Not Resuscitate order in Community □No □Yes

□Court Appointed Guardian □No □Yes, Appointee Name:

□Information given to patient/family Date Provided / /
□Patient Declines / Not Interested

2. Insurance Status □Yes □No
Insurance □Primary □Secondary □Active □Pending □Other
Insurance □Primary □Secondary □Active □Pending □Other
Insurance □Primary □Secondary □Active □Pending □Other
Veterans Service □Primary □Secondary □Active □Pending □Other

3. Transportation to Dialysis
□Drives Self □Parent/Guardian drives □Public Transportation □Family assistance □Friends assistance □Taxi (self-pay)
□Insurance funded transportation □Ambulance □Other
Is transportation reliable to/from dialysis □Yes □No, explain

4. Prior Employment - Patient (If initial-use 6 months prior to starting dialysis):
□Not Employed- Minor □Employed Full Time □Employed Part Time
□Medical Leave of Absence □Not employed - By Choice □Not Employed – Disabled
□Not Employed – Looking for Work
Occupation
Name of Employer
5. **Current Employment - Patient**

- Not Employed - Minor
- Employed Full Time
- Employed Part Time
- Medical Leave of Absence
- Not employed - By Choice
- Not Employed – Disabled
- Not Employed – Looking for Work

**Occupation**

**Name of Employer**

---

6. **Current Employment - Mother/Guardian**

- Employed Full Time
- Employed Part Time
- Medical Leave of Absence
- Not employed - By Choice
- Not Employed – Disabled
- Not Employed – Looking for Work
- Normal Age retirement
- Medical Retirement

**Occupation**

**Name of Employer**

---

7. **Current Employment - Father/Guardian**

- Employed Full Time
- Employed Part Time
- Medical Leave of Absence
- Not employed - By Choice
- Not Employed – Disabled
- Not Employed – Looking for Work
- Normal Age retirement
- Medical Retirement

**Occupation**

**Name of Employer**

---

8. **School Status:**

- Was patient enrolled in school prior to starting dialysis? [ ] No [ ] Yes [ ] Not of school age
- Homebound Instruction [ ] Home Schooled [ ] Preschool [ ] College/Vocational training
- Early Intervention Program (birth – 3 yrs) -- [ ] enrolled [ ] needs referral [ ] explain

**Name of School**

**Grade**

**School Contact Person**

**Contact number**

**Special Education/Supports:**

- IEP Plan [ ] No [ ] Yes [ ] Date
- 504 Plan [ ] No [ ] Yes [ ] Needs to be initiated [ ] explain
- Letter sent to school explaining dialysis status [ ] No [ ] Yes [ ] Date: / / 

---

9. **Vocational Rehabilitation Status, if not working:**

- Not eligible due to patient age [ ]
- Enrolled in a Vocational rehab agency [ ]
- Referred to a Vocational rehab agency [ ]
- Interested, but has not followed up [ ]
- Pursuing a vocational interest [ ]
- Not interested [ ]
- Developing Self-Help Skills [ ]

Are there barriers identified preventing positive vocational outcomes? [ ] No [ ] Yes, Explain Barriers

---

10. **Educational/Vocational Goals:**

- What are the patient’s goals?

  **Vocational goals:**
  
  **Now**
  
  The next 5 years:
  
  **Personal goals:**
  
  **Now**
  
  The next 5 years:
  
  **Educational goals:**
  
  **Now**
  
  The next 5 years:
11. Living Status:

- House
- Condo
- Mobile home
- Apartment
- Rents House
- Public Housing
- Shelter
- Group Home
- Homeless
- Long-Term care Facility (SNF)

With whom does the patient live?

- Parents
- Siblings
- Extended Family
- Significant Relative/Guardian
- Foster Home
- Lives alone
- Spouse
- Child/Children
- Significant other
- Significant Friend
- Other

Is the current living situation a barrier to positive treatment outcomes?

- No
- Yes, Describe:

Who will bring patient to dialysis/be main home dialysis caregiver?

Who will supervise home medical regimen including medication administration, diet and fluid limit?

12. Social Status

<table>
<thead>
<tr>
<th>Income</th>
<th>No problems</th>
<th>Maximum Assistance in place</th>
<th>Referral needed</th>
<th>Referral in process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td>No problems</td>
<td>Maximum Assistance in place</td>
<td>Referral needed</td>
<td>Referral in process</td>
</tr>
<tr>
<td>Medication</td>
<td>No problems</td>
<td>Maximum Assistance in place</td>
<td>Referral needed</td>
<td>Referral in process</td>
</tr>
<tr>
<td>Utilities</td>
<td>No problems</td>
<td>Maximum Assistance in place</td>
<td>Referral needed</td>
<td>Referral in process</td>
</tr>
<tr>
<td>Housing/rental</td>
<td>No problems</td>
<td>Maximum Assistance in place</td>
<td>Referral needed</td>
<td>Referral in process</td>
</tr>
<tr>
<td>Legal</td>
<td>No problems</td>
<td>Maximum Assistance in place</td>
<td>Referral needed</td>
<td>Referral in process</td>
</tr>
<tr>
<td>Immigration</td>
<td>No problems</td>
<td>Maximum Assistance in place</td>
<td>Referral needed</td>
<td>Referral in process</td>
</tr>
<tr>
<td>Other</td>
<td>No problems</td>
<td>Maximum Assistance in place</td>
<td>Referral needed</td>
<td>Referral in process</td>
</tr>
<tr>
<td>Other</td>
<td>No problems</td>
<td>Maximum Assistance in place</td>
<td>Referral needed</td>
<td>Referral in process</td>
</tr>
</tbody>
</table>

13. Learning Preference:

What is the patient's learning preference:

- Seeing
- Hearing
- Doing

What is the parent/guardian/caregiver's learning preference:

- Seeing
- Hearing
- Doing

14. Habits:

- Tobacco: N/A
- Packs per day: Years
- Alcohol: N/A
- How often: Daily
- 4 + weekly
- 2-3 Weekly
- 2-4 Monthly
- Monthly or less
- Drugs: N/A
- Name of Drug: How often: Daily
- 4 + weekly
- 2-3 Weekly
- 2-4 Monthly
- Monthly or less

Has the patient ever received Drug or Alcohol treatment? No
Yes When

Has anyone else in the family ever received Drug or Alcohol treatment? No
Yes When

15. Support System and Spirituality

Describe family composition:

Other Health Problems in the family?

Describe:

Is the patient involved in community activities, groups, sports, extracurricular activities?

- No
- Yes, Describe

What has the patient previously done for enjoyment or recreation?

Is (s) he able to engage in these activities now?

- No
- Yes

Is the patient part of a spiritual or religious community?

- No
- Yes

Describe:

Are there any specific cultural or spiritual practices/restrictions?

- No
- Yes

Describe:
16. Mental Health Status

Does the patient report any past or current mental health issues, concerns or mood disturbances, feeling of depression or anxiety?

☐ No  ☐ Yes, describe:

☐ Unknown, Reason:

Is there any history of mental health diagnosis in the patient ☐ No  ☐ Yes, record below

Is there any history of mental health diagnosis in the family ☐ No  ☐ Yes, record below

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Approximate Date of Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Has the patient participated in counseling?  ☐ No  ☐ Currently in counseling  ☐ Yes, in the past

Describe:

Name of mental health provider:

Has the patient started counseling or a support group?  ☐ No  ☐ Yes, Describe:

Are there signs/symptoms present for depression or anxiety problems?  ☐ No  ☐ Yes, complete signs and symptoms below

<table>
<thead>
<tr>
<th>Signs and Symptoms</th>
<th>Severity Level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not a Problem</td>
</tr>
<tr>
<td>Depressed mood most of the day</td>
<td></td>
</tr>
<tr>
<td>Decreased interest/pleasure in most activities</td>
<td></td>
</tr>
<tr>
<td>A problem with appetite/weight change</td>
<td></td>
</tr>
<tr>
<td>Significant sleep disturbance</td>
<td></td>
</tr>
<tr>
<td>Psychomotor retardation or agitation</td>
<td></td>
</tr>
<tr>
<td>Fatigue, loss of energy</td>
<td></td>
</tr>
<tr>
<td>Feelings of worthlessness or guilt</td>
<td></td>
</tr>
<tr>
<td>Poor concentration</td>
<td></td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td></td>
</tr>
<tr>
<td>Panic attacks</td>
<td></td>
</tr>
<tr>
<td>Irritable mood</td>
<td></td>
</tr>
</tbody>
</table>

This signs/symptoms list is not comprehensive and is not intended to diagnosis depression. Further assessment should be completed if signs/symptoms are present. Somatic symptoms may be due to medical causes.

Has the patient started taking a psychotropic medication?  ☐ No  ☐ Yes, note below

<table>
<thead>
<tr>
<th>Medication and Dosage</th>
<th>Date Started</th>
<th>Effective</th>
<th>Not Effective</th>
<th>Adverse Reaction</th>
<th>Not Yet Determined</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

17. COPING – Perform Separate Pediatric Quality of Life Assessment (PED QL) using age appropriate form

18. Primary Language

☐ English  ☐ Spanish  ☐ Other:

Is the patient/guardian/family able to read printed materials?

<table>
<thead>
<tr>
<th>Language</th>
<th>Yes</th>
<th>No</th>
<th>Limited</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
When interpretation assistance is required, how does the patient/family communicate with the care team

- N/A
- Family
- Friends and/or other social supports
- Professional Interpreter
- Community Agency
- Facility staff (able to communicate with the patient in their primary language)
- None of the above (care team unable to effectively communicate with the patient)

19. Previous history of abuse in home?  No  Yes, Please describe

20. Previous/current CPS involvement?  No  Yes, Please describe

---

**Interest and Suitability for Transplant (Complete for Initial and Annual Assessment)**

**Complete by MD – Completed by ______________________________ Date: ___/___/______**

1. Did this patient initiate dialysis AT YOUR FACILITY within the last 12 months?  Yes  No
   
   If yes, did the patient’s nephrologist or dialysis team provide information about how to get a transplant within the first 30 days of treatment?
   
   - Yes
   - No
   - Patient/family doesn’t recall

2. Has the patient been dialyzing at your facility for MORE than 12 months?  Yes  No
   
   If yes, did the patient’s nephrologist or dialysis team provide information about how to get a transplant within the last 12 months?
   
   - Yes
   - No
   - Patient/family doesn’t recall

3. Does the patient/family want to be evaluated for a kidney transplant?  Yes  No  Undecided
   
   If no, specify:
   
   - Financial barrier
   - Medical complication
   - Satisfied with dialysis
   - Age
   - Other:

4. Are there any contraindications to referring patient for transplant evaluation?  Yes  No
   
   If yes, contraindication identified by:
   
   - Transplant center
   - Dialysis facility
   
   Specify contraindication(s) as indicated by the transplant center’s selection criteria:

5. Has the patient been referred to a transplant center for an evaluation?  Yes  No  Unknown
   
   If yes, specify date: ___/___/______
   
   Specify who referred patient:
   
   - Nephrologist
   - Social worker
   - Nurse
   - Patient self-referral
   - Secretary
   - Other:

   Specify how patient was referred:
   
   - Written communication (letters, standard form, email)
   - Phone call
   - Other:

   If no, specify reasons for not referring:
   
   - Contraindication(s)
   - Patient already on the waitlist
   - Patient not interested/undecided
   - Physician judgment or refuses to refer
   - Unknown