I AM A DIALYSIS PATIENT.

VITAL INFORMATION

NAME ____________________

Toll-Free #: ____________ Network: ____________

KIDNEY COMMUNITY EMERGENCY RESPONSE (KCER) COALITION

www.kcercoalition.com

MEDICATIONS

Medication	Dose	Frequency

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: (   ) ____________________

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