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: ( ) _____

MEDICATIONS

Medication	Dose	Frequency

Pharmacy & Phone: _____

Special Needs: _____

_____

Primary Diagnosis: _____

Allergies: _____

I AM A DIALYSIS PATIENT.

VITAL INFORMATION

_____

NAME

KIDNEY COMMUNITY EMERGENCY RESPONSE (KCER) COALITION

Network: _____ Toll-Free #: _____

E-mail: kcer@nw7.esrd.net