TREATING NEPHROLOGIST TO COMPLETE

Dialysis AUSTRALIA
Care with Compassion and Commitment

HOME HAEMODIALYSIS (HHD) PATIENT REFERRAL FORM

FAMILY NAME	MRN
GIVEN NAME	[ ] MALE [ ] FEMALE
D.O.B. ____/____/____	NEPHROLOGIST
ADDRESS	
MEDICARE No:	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

CRITERIA	YES	NO	COMMENTS
1. **Requires oxygen during Haemodialysis** (Oxygen saturation is ≥ 95% on room air)			
2. **Hypertension present during Haemodialysis** (>180 mmHg)			
3. **Hypotension present during Haemodialysis** (< 90 mmHg)			
4. **Current medications** *(please attach)*			
5. **Adheres to fluid restrictions** (Retaining < 1L fluid post-dialysis)			
6. **Requires consistent heart monitoring**			
7. **Pre-dialysis observations** *(please tick)* ❑ Systolic blood pressure ≥ 100 mmHg and ≤ 180 mmHg ❑ Diastolic blood pressure ≥ 40 mmHg and ≤ 90 mmHg ❑ Pulse rate ≥ 50 bpm and ≤ 120 bpm ❑ Temperature ≥ 35.5 degC and ≤ 38.0 degC ❑ Respiratory rate ≥ 10 br pm and ≤ 25 br pm			
8. **Post-dialysis observations** *(please tick)* ❑ Systolic blood pressure ≥ 100 mmHg and ≤ 180 mmHg ❑ Diastolic blood pressure ≥ 40 mmHg and ≤ 90 mmHg ❑ Pulse rate ≥ 50 bpm and ≤ 120 bpm ❑ Temperature ≥ 35.5 degC and ≤ 38.0 degC ❑ Respiratory rate ≥ 10 br pm and ≤ 25 br pm			
9. **Evidence of substance abuse and/or aggression**			
10. **Medical history** *(please attach)*			
11. **Symptoms while on Haemodialysis**			
12. **Blood-flow rate and pressures** *(please tick)* ❑ Blood flow ≥ 250 mL/min ❑ Arterial pressure ≥ -20 mmHg ≤ -200 mmHg ❑ Venous pressure ≤ 200 mmHg			
13. **Is the patient suitable for Home Haemodialysis?**			

Comments and follow up

Vascular Surgeon name and contact number:

Nephrologist name: _____ Provider No: _____

Nephrologist signature: _____ Contact Phone No: / Mobile No:_____

Date: _____ Contact email: _____

*Completed referral forms to be emailed to **referral@dialysisaustralia.com.au***

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Version 2.1