*FOR MEDICAL RECORD STAFF USE ONLY*

HOSP ID MRN
SURNAME
OTHERNAMES
DOB SEX AMO

**MRN BAR CODE**

Affix Addressograph Label here

# PERITONEAL DIALYSIS TRANSFER FORM

**NAME:** _____

**NOK:** _____

**PHONE:** _____

**CONSULTANT:** _____

**PERMANENT TRANSFER** **YES / NO / UNSURE**

**DIAGNOSIS:** _____

**MEDICAL HISTORY:** _____

_____

_____

**ALLERGIES:** _____

**REASON FOR TRANSFER:** _____

_____

**SOCIAL SUPPORT / TRANSPORT:** _____

_____

**IDEAL BODY WEIGHT:** _____ **TRANSPLANT LIST: YES / NO**

**ARANESP/EPO:** _____

**SEROLOGY ATTENDED: YES / NO** **DATE ATTENDED:** _____

**MEDICATIONS:** _____

_____

_____

**OTHER:** _____

_____

_____

**THE ST GEORGE HOSPITAL**
BINDING MARGIN – NO WRITING

**PERITONEAL DIALYSIS TRANSFER FORM**

MRxxxx.xxx

Reviewed:
11/2011
Item No.

NO WRITING