Toronto Rehab
Advancing Rehabilitation
Enhancing Quality of Life

University Health Network
Toronto General Hospital Toronto Western Hospital Princess Margaret Hospital

Toronto Rehabilitation Institute Dialysis Service – Dialysis Application Form

***On completion please Fax to TRI dialysis co-ordinator at 416 977 8719 ***

Patient Name:		Referring Physician:
Address:		Physician contact number:
DOB:	Medical record number:	Gender: Male Female

Referral to: ☐ CCC program (long term) ☐ Geriatric Rehabilitation Program

- **ESRD secondary to:**

- Date of 1st RRT and dialysis history (previous Tx, PD, HD etc)

- Acute deterioration leading to need for Rehab due to (rehab only):

Comorbid conditions:

1. Cardiac disease Y / N details:
2. Hypertension Y / N details:
3. Diabetes Y / N details:
4. Vascular disease Y / N details:
   (includes Periph. vasc or Cerebrovasc):
5. Skin breakdown Y / N details:
6. Other comorbidity (with details)

____
____
____
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Issues for TRI dialysis team to follow on transfer:

Problems on dialysis?		Y / N	details:		
Blood work issues of concern		Y / N	details:		
Medication issues of concern		Y / N	details:		
Vasc access issues of concern		Y / N	details:		
Other issues for follow up		Y / N	details:		
Hep B Status (circle one)	HbsAg -ve		HbsAg +ve	HbsAb +ve	unknown
HIV status (circle one)	negative		positive	unknown	

1/7/10 Date (day/month/yr) ______ /________ /______

(Once completed, the referral can be faxed to 416-597-7067 in addition to the number listed above.)

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Addressograph:

Checklist of documents enclosed:

______ 3 (most recent) dialysis run sheets

______ Current medication list

______ MRSA, VRE results

______ *Lab flow sheet (if available)* OR recent bloodwork.

______ *Other pertinent medical information or recent medical summaries (if available)*

Completed by (please print CLEARLY) ____________________

RN *MD* *Other*