



Patient: _____ RHRN _____ DOB: _____
 Nephrologist: _____ Case Manager: _____

Date _____ Time _____ BP: _____ P: _____ Accompanied by _____

Allergies _____

Quality Indicators			
<input type="checkbox"/> Appetite Concerns <input type="checkbox"/> Metallic Taste <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Cramping <input type="checkbox"/> Edema <input type="checkbox"/> Pruritus <input type="checkbox"/> Rash <input type="checkbox"/> Skin Breakdown	<input type="checkbox"/> Feet Problems <input type="checkbox"/> Mobility Concern <input type="checkbox"/> Restless Legs <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Pain <input type="checkbox"/> Decreased Energy <input type="checkbox"/> SOB <input type="checkbox"/> Sleep Problems <input type="checkbox"/> Mood Concern Other: _____	Weight _____ kg <input type="checkbox"/> Weight Gain _____ kg <input type="checkbox"/> Weight Loss _____ kg	Physical Activity: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
Home BP/HR/Glucose:			
Home Care Services <input type="checkbox"/> yes <input type="checkbox"/> no Type: _____			
<input type="checkbox"/> Labs: Reviewed GFR _____		<input type="checkbox"/> Logbook: Reviewed	
<input type="checkbox"/> Modality/Access: Reviewed			
Medical Alert Bracelet: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Bubble Pack: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, frequency: _____	
Dosette: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, self-filled: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Medications: Reviewed <input type="checkbox"/> Changes (since last visit)	
Summary / Plan:			
Follow-up Appointment:			