

American Nephrology Nurses' Association

National Kidney Foundation

Comprehensive Interdisciplinary Patient Assessment (CIPA) Example Questions

Introduction to the CIPA

The Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), published the Final Conditions for Coverage (CfC) for End-Stage Renal Disease (ESRD) Facilities on April 15, 2008. In anticipation of the final publishing of the CfC for ESRD facilities, CMS encouraged the National Kidney Foundation (NKF) and American Nephrology Nurses' Association (ANNA) to establish a task force to develop resources and guidelines to assist facilities in complying with the requirement for a comprehensive, interdisciplinary patient assessment (CIPA). The CIPA replaces the requirement for individual assessments by each discipline (ref: § 494.80). The CIPA needs to be completed on the following schedule:

- The latter of 30 calendar days or 13 treatments beginning with the first outpatient dialysis session for all new patients, without regard to the modality of treatment. Patients changing modalities are also considered “new” patients.
- 3 months after the completion of the initial assessment and within 3 months for an established dialysis patient transferring from one dialysis facility to another.
- At least annually for stable patients – due 12 months after the 3-month reassessment or 15 months after the patient’s admission to the facility.
- At least monthly for unstable patients, including but not limited to, patients with the following:
 - ✓ Extended or frequent hospitalizations – defined as a hospitalization greater than 15 days and/or more than 3 hospitalizations in a month;
 - ✓ Marked deterioration in health status;
 - ✓ Significant change in psychosocial needs, which includes any patient considered at risk for involuntary discharge or transfer; or
 - ✓ Concurrent poor nutritional status, unmanaged anemia, and inadequate dialysis.

Initial and annual assessments are anticipated to be more comprehensive in nature than other assessments. When a patient’s unstable status triggers a new assessment, the reassessment will likely be more narrow in focus. If the trigger for reassessment is clearly within the purview of a specific member of the team, the participation of the remaining team members may be “limited.” However, there should be documentation that the other team members were notified of the triggering event and that they assessed the potential impact on their areas of specialty.

In addition to the CIPA schedule, the adequacy of the patient’s dialysis prescription must be assessed as follows:

- *Hemodialysis Patients:* At least monthly by calculating delivered Kt/V or an equivalent measure
- *Peritoneal Dialysis Patients:* At least every 4 months by calculating delivered weekly Kt/V or an equivalent measure

Minimum Criteria of the Assessment


The CIPA must consist of the following minimum criteria:

- Evaluation of current health status and medical condition, including co-morbid conditions
- Evaluation of the appropriateness of the dialysis prescription, blood pressure, and fluid management needs
- Laboratory profile, immunization history, and medication history
- Evaluation of factors associated with anemia, such as hematocrit, hemoglobin, iron stores, and potential treatment plans for anemia, including administration of erythropoiesis-stimulating agent(s)
- Evaluation of factors associated with renal bone disease
- Evaluation of nutritional status by a dietitian
- Evaluation of psychosocial needs by a social worker
- Evaluation of dialysis access type and maintenance (for example, arteriovenous fistulas, arteriovenous grafts, and peritoneal catheters)
- Evaluation of the patient's abilities, interests, preferences, and goals, including the desired level of participation in the dialysis care process; the preferred modality (hemodialysis or peritoneal dialysis) and setting (for example, home dialysis), and the patient's expectations for care outcomes
- Evaluation of suitability for a transplantation referral, based on criteria developed by the prospective transplantation center and its surgeon(s). If the patient is not suitable for transplantation referral, the basis for nonreferral must be documented in the patient's medical record
- Evaluation of family and other support systems
- Evaluation of patient's current physical activity level
- Evaluation for referral to vocational and physical rehabilitation services

Completion of Assessment

The interdisciplinary team is responsible for the completion of the assessment. The team, as defined in the CfC, includes: the patient or the patient's designee (if the patient chooses), a registered nurse, a physician treating the patient for ESRD, a social worker and a dietitian. Each member of the team should contribute to the completion of the assessment. The CfC designates two areas to specific team members – Evaluation of Nutritional Status to the dietitian and Evaluation of Psychosocial Needs to the social worker. It is anticipated that each facility and treatment team will individually determine who is responsible for completing the remaining criteria based on their clinical judgment, professional expertise, and organizational structure. Team members should consult with each other in the process of completing the assessment in order to reach agreement on assessment points and to ensure integration.

Example Assessment Questions

The following set of questions was created as an example to ensure compliance with the CfC and to aid in the development of an effective plan of care. For responses noted in shaded boxes “,” it is anticipated that the item will need to be addressed in the plan of care.

Patients have the right to refuse to answer questions and to refuse to participate in non-essential assessments. If a patient refuses to provide information for an assessment item, the team should document the patient’s refusal.

Assessment to Plan of Care

The CIPA is the first step in the care planning process and will generate a list of problems. The care team will create or adjust the plan of care to address the problems identified by the CIPA. The CfC (§494.90) state that the Plan of Care must:

- Be individualized
- Specify the services necessary to address the patient’s needs identified in the assessment
- Include measurable and expected outcomes
- Include estimated timetables to achieve outcomes
- Contain outcomes consistent with current evidence-base professionally-accepted clinical practice standards

The example assessment questions have been designed in such a way to try to allow for the measurement of progress, the use of evidenced-based assessment tools, and the engagement of the patient in the assessment process. This example is in no way intended as the absolute requirement. This CIPA is an example of one possibility to meet the expectations and should in no way be interpreted as a requirement to facilities. It is expected facilities will modify the CIPA based on their own documentation systems.

Disclaimer

This document was created for educational purposes only. The assessment questions are intended to provide examples of the types of questions that physicians, registered nurses, dietitians, and social workers may want to use to meet the requirements for a CIPA. The validity and reliability of the questions have not been confirmed. It is the responsibility of the user to verify that the use of any of the questions from cited sources does not violate any copyright laws.

The implementation and interpretation of the new Conditions for Coverage for End-Stage Renal Disease Facilities is anticipated to be a dynamic process. This document reflects the information available to the kidney community as of its version date. Please confirm with NKF or ANNA whether further information, resources, or guidance has been provided on this subject. The information provided is not intended to establish or replace policies and procedures provided by dialysis providers to their facilities. Please check with your dialysis facility management before implementing any information provided here.

Reason for Assessment

Complete for each assessment

R1. State Reason for Assessment

- Initial 90 day Annual (stable patients) Monthly (unstable patients)

R1a. If monthly, choose reason for unstable status. Choose all that apply.

- Hospitalization – frequent or extended stay
 Marked deterioration in health status
 Change in psychosocial needs
 Poor nutritional status and unmanaged anemia and inadequate dialysis

Other:

Demographics

Complete for initial assessment only

D1. What is the patient's name?

Last name:

Legal first name:

Preferred first name:

Middle initial:

D2. What is the patient's date of birth?

/ /

D3. What is the patient's sex?

- Male
 Female
 Intersex, transsexual, or other:
(Please specify)

D4. What is the patient's gender identity?

(Check all that apply)

- Woman
 Transgender
 Man
 Other:

D5. Is the patient of Hispanic or Latino origin or descent? (2728 Coding)

Yes

What is their country/area of origin or ancestry?

No

D6. What is the patient's race? (2728 Coding)

- White
 Black or African American
 American Indian/Alaska Native

What is the name of Enrolled/Principal Tribe?

- Asian
 Native Hawaiian or Other Pacific Islander

What is their county/area of origin or ancestry?

D7. What is the date of the patient's first chronic dialysis treatment?

/ /

D8. What is the date the patient started chronic dialysis at the current facility?

/ /

D9. What is the patient's learning preference:

- Seeing Hearing
 Doing

Medical History

Complete for initial assessment only

N1. Cardiovascular N/A

- Cardiomyopathy: Ischemic Hypertrophic Unknown
 Ischemic heart disease: Angina at rest
 Angina on exertion
 Angina on dialysis
- Heart failure: Left Right Unknown
 Dysrhythmia: Atrial fibrillation Ventricular dysrhythmia
 Hypertension
 Left ventricular hypertrophy
 Myocardial infarction
 Coronary artery bypass graft
 Pacemaker
 Internal defibrillator
 Endocarditis
 Pericarditis
 Heart transplant
 Valvular heart disease
 Ischemic Skin Lesions No Yes Treatment:
 Peripheral vascular disease
Amputation: Yes No
If yes, specify body part:
 Aortic aneurysms
 Renal artery stenosis
 Dyslipidemia
 ESA prior to dialysis initiation Yes No
If yes, which type and dose if known:
 Iron dosing prior to dialysis initiation Yes No
If yes, type, dose and freq:
 Prior transfusions Yes No If yes, explain:
 Transfusion reactions
Explanations:

N2. Pulmonary N/A

- Asthma Chronic obstructive pulmonary disease (COPD)
 Allergic rhinitis Tuberculosis (TB)
 Sarcoidosis Supplemental oxygen dependence
 Tobacco history and/or use Exposure to second hand smoke
 Smoking cessation education provided
 Sleep apnea Treatment for sleep apnea
 Other:

Explanations:

N3. Endocrine N/A

- | | | |
|---|---|--|
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Hypothyroidism | |
| <input checked="" type="checkbox"/> Secondary hyperparathyroidism | | |
| <input checked="" type="checkbox"/> Vitamin D insufficiency or deficiency | | |
| <input type="checkbox"/> Parathyroidectomy | | |
| <input checked="" type="checkbox"/> Diabetes mellitus | | |
| <input type="checkbox"/> Type I | <input type="checkbox"/> Diet-controlled | <input type="checkbox"/> Self-monitoring |
| <input type="checkbox"/> Type II | <input type="checkbox"/> Insulin-controlled | |

Explanations:

N4. Gastrointestinal Disorders N/A

- | | |
|---|---|
| <input checked="" type="checkbox"/> Constipation | <input checked="" type="checkbox"/> Diarrhea |
| <input checked="" type="checkbox"/> Poor appetite | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> GERD (gastroesophageal reflux disease) |
| <input type="checkbox"/> Esophageal disorders | <input type="checkbox"/> Dysphagia |
| <input checked="" type="checkbox"/> Gastroparesis | <input type="checkbox"/> GI bleeding |
| <input type="checkbox"/> Peptic ulcer disease | <input type="checkbox"/> Feeling of fullness (PD patients) |
| <input type="checkbox"/> GI disease | <input type="checkbox"/> Liver transplant |

Specify:

Explanations:

N5. Neurological Disorders N/A

- | | |
|---|---|
| <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> TIA (transient ischemic attacks) |
| <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> Dysphagia |
| <input type="checkbox"/> Carpal tunnel syndrome | <input checked="" type="checkbox"/> Peripheral neuropathy |
| <input type="checkbox"/> Restless leg syndrome | <input type="checkbox"/> Parkinson's disease |

Explanations:

N6. Musculoskeletal N/A

- | | |
|--|---|
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Osteoporosis | <input checked="" type="checkbox"/> Metabolic bone disease of CKD |
| <input type="checkbox"/> Fractures (explain below) | <input type="checkbox"/> Joint replacements |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Back Injury | |

Explanations:

N7. Genitourinary N/A

- | | |
|--|---|
| <input type="checkbox"/> Residual urine | <input type="checkbox"/> Painful urination |
| Volume/day: | <input type="checkbox"/> Gynecological issues |
| <input type="checkbox"/> Prostate issues | <input type="checkbox"/> Pregnancy issues |

Explanations:

N8. Immune N/A

- Amyloidosis
- HIV/AIDS
- Scleroderma
- Other
- Systemic lupus erythematosus (SLE)

Explanations:

N9. Mental Health N/A

Does the patient report any past or current mental health issues, concerns, or mood disturbances (*feelings of depression or anxiety*)?

Yes No

- Dementia
- Anxiety disorder
- Depression
- Alcohol or substance abuse
- Post-traumatic stress syndrome
- Other
- Alzheimer's
- Bipolar disorder
- Schizophrenia

Explanations:

N10. Cancer N/A

- Breast
- Gynecologic
- Lung
- Prostate
- Multiple myeloma
- Bone
- Other
- Colon
- Hematologic
- Melanoma
- Renal
- Skin
 - Squamous cell
 - Basal cell
 - Other:

Explanations:

N11. Infection N/A

- Acute Hepatitis B
- Acute Hepatitis C
- Respiratory infection
- Recent exposure to communicable disease:
- History of at risk behavior (unprotected sex, IV drug abuse)
- MRSA within the last 5 years
- History of VRE or other drug-resistant bacteria
- Infected ulcers or pressure sores:
- Access related infection: Specify:
- Peritonitis
- Bacteremia or septicemia
- Other:

Vaccination Status

- Influenza Up to date not a candidate or refuses needs vaccine
- Pneumococcal Up to date not a candidate or refuses needs vaccine
- Hepatitis B series completed series in process not a candidate or refuses needs vaccine series started or booster

Explanations:

N12. Hematologic Conditions N/A

- Sickle cell disease
- Bleeding disorder
- Other
- Heparin allergy
- Heparin-induced thrombocytopenia

Explanations:

N13. Head Ears Eyes Nose Throat (HEENT) N/A

- Retinopathy
- Impaired vision
- Dental status
 - Good dentition
 - Poor dentition
 - Dentures
 - Difficulty chewing
 - Difficulty swallowing
- Glaucoma
- Hearing loss
- Other:

Explanations:

N14. Miscellaneous N/A

N15. Surgical History N/A

Complete for each reassessment

N16. Has the patient experienced any events or developed any new conditions since last assessed, such as fall, surgery, illness, or deterioration in status? List any additions to the above co-morbid conditions. Check box if care planning needed.
Explanations:

Evaluation of Current Health Status

Complete for each assessment

HS1. Other providers involved in patient's care
(Include area of practice such as primary care, OB, etc. Telephone numbers are helpful.)

Dentist
Mental health provider

HS2. General Health Status
How does the patient rate his/her health status? Good Fair Poor
Dates of most recent routine health screening
Colonoscopy: PAP:
Mammogram: Prostate screening:
Dental exam:
Other:

HS3. ESRD diagnosis from 2728 if available:
Do you know what caused your kidneys to stop working?

HS4. Cardiac or radiologic results if available, include dates:

HS5. Nursing Review of Systems Assessment

Level of consciousness: Is patient alert? Yes No Oriented x 3? Yes No
Responsive to stimuli? Yes No
Explanations

Heart sounds, – rate, rhythm, abnormal sounds:

Fluid status –

chronically over chronically under at target weight

Neck veins: distention flat

Periphery – edema, perfusion, lack of skin turgor

Dry tongue Yes No

Chest pain Yes No

Palpitations Yes No

Dizziness or light-headedness Yes No

Explanations

Lung sounds:

Labored breathing Yes No Cyanosis Yes No

Cough Yes No Shortness of breath Yes No

Sputum production? Yes No

Does the patient use oxygen? Yes No

Explanations

GI:

Bowel patterns:

Abdominal distention – fluid related or motility related

Bowel sounds

Is the patient continent of bowel? Yes No

Constipation Yes No

Nausea/Vomiting Yes No

Diarrhea Yes No

Abdominal discomfort Yes No

Anorexia Yes No

Difficulty swallowing Yes No

Explanations

GU:

Residual urine volume: greater than 1 cup/day less than 1 cup/day

actual or estimated output

Is the urine clear? Yes No

Pain with urination? Yes No

Is the patient continent of bladder? Yes No

Explanations

Extremities:

Edema include location and degree:

Skin integrity: Do you have any areas of broken skin? Yes No

Access:

What problems cause you concern? Please tell me about those.

HS6. Medication History (including OTC)

Allergies reviewed: Yes No What is patient allergic to?

Medications reviewed: Yes No

Do you have another provider prescribing medications? Yes No

Which medications and what is the provider's name?

What pharmacy do you use?

Do you have problems related to the medications you take?

HS7. Laboratory Profile

Lab results reviewed:

HS8. Immunization History

Immunization status reviewed and up to date Yes No

If no, what immunization(s) are due? ⁹

Appropriateness of Dialysis Prescription

DP1. Volume Status

Blood Pressure Elevated (K/DOQI C-level Recommendation 140/90 Predialysis)

Yes No

Blood Volume Monitoring shows refill (if available) Yes No

Estimated dry weight:

Chronically unable to achieve dry weight Yes No

DP2. Patients on Hemodialysis N/A

Adequacy meeting targets: Yes No

If no, why:

Is Kt/V adjusted for > 3 hemo treatments/week : Yes No

Adverse Intradialytic Symptoms

Interdialytic Weight Gains:

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hypotension |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hypoxemia |
| <input type="checkbox"/> Cardiovascular complication | |

Dialysate Chemistries

K: Ca⁺⁺: Bicarb: Na: Temp:

Delivery system:

Comments:

DP3. Patients on Peritoneal Dialysis N/A

CCPD CAPD Total daily volume: _____ Kt/V
PET results Low Low average High average High
Usual Dextrose:
 Icodextran Which exchange:

Evaluation of Anemia Management

Complete for each assessment

A1. Anemia Evaluation

Is Hgb 10-12? Yes No
Hgb: _____ Retic: _____ CHr: _____ WBC: _____
Ferritin: _____ Tsat: _____ Iron: _____ TIBC: _____
Active infection? Yes No
Organism: _____
Co-morbid conditions affecting anemia: Yes No
If yes, what?
Recent transfusions: Yes No
Predisposition to bleeding? Yes No
Rapid change in Hgb? Yes No
Occult blood tested? Yes No
If yes, date and results:
ESA name: _____ ESA dose: _____ Date of last ESA change: _____
Iron dose: _____ Date of last iron dose change: _____
Other:

Factors Associated With Nutritional Status

Complete for each assessment

NS1. Anthropometrics

Height: _____ Estimated dry weight: _____ BMI: _____
Usual body weight: _____ % UBW: _____ Recent weight change? Yes No
 Weight loss greater than 5% in one month
Frame size: Small Medium Large
Adjusted body weight:
 for obesity
 for amputees
Nutrition-related medications:
 Vitamin supplement GI medications
 Stool softeners Non-Rx vitamin/minerals
 Other:

NS2. Diabetes Self-Management N/A

Diet:

Foot checks: Yes No If yes, how often: _____ By who: _____
Dental care: Daily brushing? 0 1 2 3+ Daily flossing? Yes No

Regular check-ups? Yes No

Blood glucose monitoring frequency:

Device brand:

Usual blood glucose:

Hgb A1C:

Diabetes medications: oral agent insulin type _____ dose _____

Education:

Diabetes Management:

Comments:

NS3. Mineral Bone Disorder Management

Lab Review:

Phosphorus: Trends: usually in goal usually high other

Calcium: Trends: usually in goal usually high other

PTH: Trends: usually in goal usually high other

Medications: phosphorus binder Adherence good fair poor

calcium supplement

vitamin D

IV

Oral

Diet issues: Adherence good fair poor

Education: Understands diet Yes No

Comments:

NS4. Cultural Factors Related to Diet

Religious food preferences:

Cultural foods:

Party responsible for purchasing and preparing food: patient spouse other:

Reading ability:

Primary language for food prep: English Spanish Other:

Vision: good glasses contacts blind

Hearing: good hearing aids hard of hearing

Lives alone? Yes No

Has meals alone? Yes No

People with whom meals are shared:

Frequency for dining out: number of meals eaten out/week:

Types of food usually ordered:

Does patient receive food assistance? Yes No

If yes, source:

NS5. Subjective Data

Appetite: improving decreasing good fair poor
Typical meal pattern: morning: noon: evening:
Usual intake (24-hour recall):
Number of meals/day: number of snacks/day:
Food preferences:
Food allergies:
Pica? Yes No Type: clay dirt starch ice chalk

Other:
Nutritional supplements, including enteral nutritional supplements, herbal, minerals, and vitamins not previously listed:
Previous diets/nutrition education:
Weight history, patient's desired weight:
Weight changes: planned unplanned loss gain amount
Dentition status: good fair poor
Does dentition affect ability to eat? Yes No

NS6. Objective Data

Albumin: nPCR: K:
Evaluation of nutritional intake: calories adequate inadequate:
Protein adequate inadequate
Variety of food groups adequate inadequate:
Evaluation of nutritional status: stable unstable

Evaluation of Dialysis Access

[Complete for each assessment](#)

DA1. Hemodialysis
Type of access: Simple fistula Transposed vein
Graft: Poly Vectra Other
 Catheter (see catheter section DA8)
Location:
Date placed: Surgeon:
Previous access history:

DA2. Average Blood Flow Rate (BFR):
Average arterial pressure: Average venous pressure:
Cannulation method:
Buttonhole: Rotation:

DA3. Does patient use any preparation to limit pain with needle insertion: Yes No
 Lidocaine intradermal Lidocaine cream Lidocaine patch
 Emla cream Emla patch Ethyl chloride spray Other:
Venous mapping done prior to placement: Yes No

DA4. Anticoagulation

Heparin dose:

Other home anticoagulation medication: Yes No

Explanation:

DA5. History of infection: Yes No Hospital Acquired Yes No

If yes, organism

- Staph aureus
- Staph aureus methicillin resistant (MRSA)
- Staph epi
- Staph epi methicillin resistant
- Enterococcus
- Enterococcus vancomycin resistant (VRE)
- EColi
- Pseudomonas
- Other:

Treatment:

- Vancomycin
- Cefazolin
- Gentamycin
- Azactam
- Linezolid
- Other:

DA6. Physical description of access: Straight Curved Loop tortuous Aneurisms

Direction of flow:

Other:

DA7. Access Surveillance Method

- Physical finding (persistent swelling, collateral veins, prolonged bleeding, altered characteristics of pulse or thrill)
- Intra-access flow Method
- Static pressure Method
- Duplex ultrasound
- Recirculation

Interventions required Yes No

Angioplasty Date: Where:

Surgical Revision Date: Where:

Declotting procedures Date: Where:

DA8. Catheter

Type of central venous catheter: Quinton Arrow Other
Temporary catheter: Quinton Other

Catheter Dysfunction

Manipulation or replacement Date: Where:
 Thrombolytic agent Alteplase Urokinase Other Frequency
 Reversed lines

DA9. Peritoneal Dialysis

Type of catheter: Straight Coiled Swan neck Cruz Other
Insertion date:

Thrombolytic agent Alteplase Urokinase Heparin Other
Frequency: Dose:
Catheter function:
 Patent Migration Repositioned/replaced

DA10. History of exit site infections: Yes No

If yes, organism

- Staph aureus
- Staph aureus methicillin resistant (MRSA)
- Staph epi
- Staph epi methicillin resistant
- Enterococcus
- Enterococcus vancomycin resistant (VRE)
- EColi
- Pseudomonas
- Fungus
- Other:

Treatment

- Vancomycin
- Cefazolin
- Gentamycin
- Azactam
- Linezolid
- Other:

DA11. Exit site care Soap and water Other:

Is antibiotic cream used: Yes No
Exit site width:
Cuff status:
Recent trauma:

Evaluation of Physical Activity

Complete for each assessment

PA1. Activity assessment (exercise activity is equal to 30 minutes)

- Inactive (1 or less exercise activities per week)
 Inactive light (1 to 2 exercise activities per week)
 Active (3 to 4 exercise activities per week)

PA2. Type of activity

- Walking Jogging
 Bicycling Swimming
 Conditioning or weight training Dancing
 Home activities such as gardening or snow shoveling
 Other activities:

PA3. Waist girth and waist-to-girth ratio (optional)

To calculate ratio: In a relaxed standing position, measure the narrowest point at waist and divide this by measuring the widest point of hips. A value greater than 0.8 for women and 0.9 for men have a higher risk to develop conditions such as heart disease, high blood pressure, or diabetes.

Is patient at an increased health risk: Yes No

PA4. Physical limitations: Yes No

Explanation:

PA5. Does patient desire to start or increase activity level? Yes No

Explanation:

Comments:

Fall Assessment

Complete for each assessment

F1. Assessment of balance score:

Assessment of gait score:

Method used: Example: Tinetti assessment ⁷

Other assessment:

F2. Past history of falls: Yes No

F3. Physical limitations:

F4. Known or diagnosed cognitive deficits reported by patient or family:

F5. Medications (psychotropics/sedatives/hypnotics/antihistamines/alcohol/pain/etc.):

F6. Assistive devices: None Cane/Crutch Walker Manual wheelchair
 Electric wheelchair Limb prosthesis

F7. Postural hypotension:

F8. Do you have strategies for avoiding falls? Yes No
Explanation:

F9. Patient risk for fall: low moderate high

Pain Assessment

Complete for each assessment

P1. Frequency of pain
 No pain
 Pain daily
 Pain every other day
 Pain weekly
 Pain monthly
 Pain related only to a specific activity:

Intensity of pain
 Mild
 Moderate
 Times when pain is excruciating

P2. Location of pain:
Character of pain: throbbing burning stabbing aching
How long ago did you start experiencing this type of pain?
Worst pain you ever had:

P3. Intensity of pain on a scale from 1-10 with 10 the worst pain you ever experienced:

P4. How much does pain affect your life?
What do you do to decrease/eliminate pain?
What makes the pain worse?

P5. Are you taking medications for pain? Yes No
If yes, what medications:
Does the medication provide relief? Yes No
What side effects do you experience?
Do you have other strategies for dealing with pain?
How do you respond to pain (i.e., cry out, moan, become withdrawn or angry, etc.)?

Communication Status**Complete for initial assessment and at least annually****CS1.** Are there physical or cognitive barriers that affect the patient's ability to communicate? Yes No**CS1a.** If yes, describe:**CS2.** Are there any barriers to the patient's ability to communicate verbally in English?
EXCLUSIVE OF COGNITIVE OR PHYSICAL BARRIERS?

Assessment of Patient's Ability to Communicate in English		
No Limitation	Barriers Present	
	<input checked="" type="checkbox"/>	Not able to communicate in English <i>Requires interpretation assistance at all times</i>
	<input checked="" type="checkbox"/>	Only able to communicate basic needs to staff <i>Uses single words or short phrases – requires interpretation assistance for conversations and care planning</i>
	<input type="checkbox"/>	Able to communicate with staff in most situations <i>Able to carry on conversations with staff. Requires occasional interpretation assistance for more complex conversations.</i>
<input type="checkbox"/>		Able to communicate in English

If a BARRIER IS PRESENT, answer the following questions:

CS2a. What is the patient's primary language for communicating with facility staff?**CS2b.** When interpretation assistance is required, how does the patient communicate with the care team? (Check all that apply)

<input type="checkbox"/>	Family
<input type="checkbox"/>	Friends and/or other social supports
<input type="checkbox"/>	Professional interpreter
<input type="checkbox"/>	Community agency
<input type="checkbox"/>	Facility staff (able to communicate with the patient in their primary language)
<input type="checkbox"/>	None of the above (care team unable to effectively communicate with the patient)

CS3. Is the patient able to read printed materials?

Language	Yes	No	Limited	Details
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

Advance Care Planning

[Complete for each assessment](#)

AP1. Does patient have any of the following?

	Yes	No	Copy at Facility	
Advance Directive (<i>living will, durable power of attorney for healthcare, and health care proxy</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Appointee:
Do Not Resuscitate Order at Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Do Not Resuscitate Order in Community	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Court Appointed Guardian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Appointee:
Durable Power of Attorney for Financial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Appointee:

AP1a. If the patient DOES NOT have an advance directive, does the patient or a support person want information on advance directives?

- Yes
- No - not interested
- No - already has
- Unknown

AP2. If the patient has a “Do Not Resuscitate Order” at facility or in the community, does the patient have pre-funeral arrangements made?

- Yes
- No
- Unknown

AP2a. If yes, list name and phone number of funeral home and other details:

Social Barriers

[Complete for each assessment](#)

SB1. Have there been any changes to the patient’s insurance status since the last assessment? (If initial assessment mark “Yes”) Yes No

SB1a. If yes, what is the patient's current insurance status?

Insurance	Active	Pending	Primary	Secondary	Other
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> No Insurance					

Comments:

SB2. Is the patient's insurance status a barrier to positive treatment outcomes? Yes No

SB2a. If yes, explain:

Examples: unable to afford co-pays, difficulty paying monthly premiums, etc.

SB3. What is the patient's mode of transportation to dialysis? (Check all that apply)

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Walk | <input type="checkbox"/> Taxi (Self-pay) |
| <input type="checkbox"/> Drives self | <input type="checkbox"/> ADA transport |
| <input type="checkbox"/> Public bus | <input type="checkbox"/> Insurance funded transport |
| <input type="checkbox"/> Family | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Friends | <input type="checkbox"/> Other: |

SB4. Does the patient have reliable transportation to/from dialysis? Yes No

SB4a. If no, explain:

SB5. Is the patient currently a student? Yes No

SB5a. If yes, explain:

SB6. What is the patient's employment status?

Prior Employment If INITIAL – use 6 months prior to starting dialysis If REASSESSMENT – use status at last assessment	Current Employment
<input type="checkbox"/> Employed full-time	<input checked="" type="checkbox"/> Employed full-time
<input type="checkbox"/> Employed part-time	<input checked="" type="checkbox"/> Employed part-time
<input type="checkbox"/> Retired	<input checked="" type="checkbox"/> Retired
<input type="checkbox"/> Medical leave of absence	<input checked="" type="checkbox"/> Medical leave of absence
<input type="checkbox"/> Not employed - by choice	<input checked="" type="checkbox"/> Not employed - by choice
<input type="checkbox"/> Not employed - looking for work	<input checked="" type="checkbox"/> Not employed - looking for work
<input type="checkbox"/> Not employed - disabled	<input checked="" type="checkbox"/> Not employed - disabled

SB6a. If NOT working, what is the patient's vocational rehabilitation status?

- Already working with VR agency
- Patient referred to VR
- Patient has expressed interest in VR but has not followed up
- Patient not interested
- Patient not eligible
- Patient looking for employment on own

SB7. Is the patient's dialysis a barrier to positive vocational outcomes? Yes No

SB7a. If yes, what barriers does the patient report that prevents him /her from working or attending school?

Examples: missing workdays, not enough energy to perform job, not able to attend school, etc.

SB8. What is the patient's status with regard to the following social needs?

	No problems reported	Maximum assistance in place	Referral needed or in process
Income (wages, social security, welfare, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Food	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Utilities	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Housing/Rent	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Legal	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Immigration	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Mobility Status, Activities of Daily Living, & Physical Rehabilitation

Complete for each assessment

A1. Has the patient been referred for physical rehabilitation services? Yes No

A1a. If no, does the patient want to be referred to physical rehabilitation? Yes No

A2. Level of Assistance with Activities of Daily Living

<input type="checkbox"/> Independent	
<input type="checkbox"/> Assistance required: (Indicate activities requiring assistance)	
<input type="checkbox"/> Bathing	<input type="checkbox"/> Laundry
<input type="checkbox"/> Toileting	<input type="checkbox"/> Transportation
<input type="checkbox"/> Dressing	<input type="checkbox"/> Shopping
<input type="checkbox"/> Medication management	<input type="checkbox"/> Finances
<input type="checkbox"/> Meal preparation	<input type="checkbox"/> Medical appointments
<input type="checkbox"/> Housekeeping	<input type="checkbox"/> Other:
<input type="checkbox"/> Requires total care	

If assistance is REQUIRED (or total care required), **answer these questions:**

A2a. Is there adequate support or services in place to provide assistance?

- Yes
 No

A2b. Describe support or services in place: (include persons providing assistance, barriers, and/or lack of assistance):

Living Situation

Complete for each assessment

L1. With whom does the patient live?

- Lives alone
 Parents
 Spouse
 Child/children
 Significant other/friend/relative
 Other:

L3. Is the patient's current living situation a barrier to positive treatment outcomes?

- Yes
 No

L3a. If yes, describe barrier:

L2. Where does the patient reside?

- | | |
|--|--|
| <input type="checkbox"/> Owns home/condo/mobile home | <input checked="" type="checkbox"/> Acute rehabilitation center |
| <input type="checkbox"/> Rents apt/house | <input checked="" type="checkbox"/> Shelter |
| <input type="checkbox"/> Assisted living | <input type="checkbox"/> Correctional facility |
| <input type="checkbox"/> Public housing | <input checked="" type="checkbox"/> Homeless |
| <input checked="" type="checkbox"/> Long-term care facility (nursing home) | <input checked="" type="checkbox"/> Adult family home/group home |

Support System & Spirituality¹

Complete for initial assessment and at least annually

S1. What is the patient's relationship status?

- Domestic partner Single
 Married Widowed
 Divorced Separated

S2. Describe family composition: *Dependent children, relatives in the home, etc.*

S3. What is the level of involvement of family and friends on a regular basis with the patient? *Visits, phone calls, emails, etc*

- Daily
 Weekly
 Monthly
 Less frequently than monthly

S4. How does the patient cope with life events and daily stress? (Check all that apply)

- Keeps it to him/herself
 Talk to family
 Talk to friends
 Pray
 Talk with a professional
 Support group
 Resources on the Internet

S5. Is the patient involved in community activities, groups, social events, or volunteering?

- Yes
 No

S5a. If yes, describe:

S6. What has the patient previously done for enjoyment or recreation?

S6a. Is (s)he able to engage in these activities now?

- Yes
 No

S7. Does the patient report having adequate support (patient's perspective)?

- Yes
 No

S7a. If no, what support is desired:

Complete for initial assessment only

S8. Is the patient part of a spiritual or religious community? Yes No

Describe:

S9. Are there any specific cultural or spiritual practices/restrictions the health care team should know about in providing the patient's medical care? *Dietary restrictions, use of blood products*

- Yes No Describe:

Cognitive Patterns & Cognitive Skills for Daily Decision-making ²

Complete for each assessment

C1. Is there evidence of a change in cognitive status from the patient's baseline since the last assessment? (if initial assessment, compare to reported status 6 months prior to starting dialysis treatments)

- Yes
 No

C2. The patient's ability to make decisions regarding daily life:

- Independent
 Modified independence – *some difficulty in new situations*
 Moderately impaired – *requires assistance in making decisions*
 Severely impaired – *never/rarely makes decisions*

C3. Does the patient appear to have a problem with the following?

- Short-term memory Yes No
 Long-term memory Yes No

C3a. If yes, check all that the patient was normally ABLE to recall during the last 5 days

- Current season
 Day of the week
 Staff names and faces
 That (s)he is in a dialysis facility
 None of the above is recalled

C4. During the past 2 weeks, has the patient demonstrated any of the following behaviors? ²

CAM Confusion Assessment Method

Behavior	Behavior not present	Behavior continuously present, does <u>not</u> fluctuate	Behavior present, fluctuates (comes and goes, changes in severity)
a. Inattention – Did the patient have difficulty focusing attention (<i>easily distracted, out of touch, or difficulty keeping track of what was said</i>)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
b. Disorganized thinking – Was the patient's thinking disorganized or incoherent (<i>rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject</i>)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
c. Altered level of consciousness – Did the patient have altered level of consciousness (<i>not related to low blood pressure</i>)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
d. Psychomotor retardation – Did the patient have an unusually decreased level of activity (<i>sluggishness, staring into space, moving slowly</i>)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

C4a. What sources of information were used in answering this section?

- Patient's self-report Observations of dialysis staff Social supports/family
 Medical records Other:

C4b. Does the patient's behavior change during dialysis treatments? Yes No

Describe:

Mental Health Status**Complete for initial assessment only****M1.** Has the patient participated in counseling?

- Yes in the past
 Currently in counseling
 No

M1a. If yes or CURRENTLY in counseling, how does the patient describe his/her counseling experience?

Describe:

M2. Has the patient ever taken a psychotropic medication? (*Possible interview question: "Have you ever taken any medication to help you relax, to help you sleep or to help you feel less sad or less angry?"*)

- Yes No
 Unknown

Comments:

M3. Does the patient report any history of substance use?*(Possible interview question: "Have you ever used a substance other than alcohol, such as a drug, to help you calm down, feel better, reduce pressure on yourself, or just have fun?")*

- Yes No

M3a. If yes, complete the following:

Drug	Current Use	If currently using, frequency			
		Less than monthly	Monthly	Weekly	Daily or almost daily
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

M4. Has the patient ever received drug or alcohol treatment?

- Yes No

M4a. If yes, describe:

M5. Ask the patient the following questions, (A.U.D.I.T Questions ⁵)

If unable to interview patient, specify reason:

M5a. How often do you have a drink containing alcohol?

- Never
- Monthly or less
- 2 to 4 times a month
- 2 to 3 times a week
- 4 or more times a week

M5b. How many drinks containing alcohol do you have on a typical day when you are drinking?

- N/A – never drinks
- 1 or 2
- 3 or 4
- 5 or 6
- 7,8, or 9
- 10 or more

M5c. Has a relative, friend, doctor, or another health worker been concerned about your drinking or suggested that you cut down?

- No or never drinks
- Yes, but not in the last year
- Yes, during the last year

Complete for each assessment

M6. Are there signs/symptoms present for depression or anxiety problems?

Yes No

M6a. If yes, what are the signs/symptoms and their severity level?

Signs/Symptoms	Severity Level			
	Not a problem	Mild	Moderate	Severe
Depressed mood most of the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased interest/pleasure in most activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A problem with appetite/weight change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Significant sleep disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychomotor retardation or agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue, loss of energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feelings of worthlessness or guilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Early awakening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

This signs/symptoms list is derived from the Diagnostic and Statistical Manual of Mental Disorders (DSM). The list is not comprehensive and is not intended to diagnosis depression. Further assessment should be completed if signs/symptoms are present. Somatic symptoms may be due to medical causes.

Complete for each assessment (EXCEPT FOR INITIAL ASSESSMENT)

M7. Has the patient started taking a psychotropic medication?

Yes No

M7a. If yes, list medication(s) and effectiveness per patient's report

Name of Medication & Dosage	Date Started	Effective	Not Effective	Adverse Reaction	Not Yet Determined
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

M8. Has the patient started counseling or a support group?

Yes No

M8a. If yes, describe:

*Depression Screening Questions (PHQ-2)*⁶

M9. Questions:

If unable to interview patient, specify reason:

Say to the patient: "Over the past two weeks, have you often been bothered by:"

	Yes	No
1. Little interest or pleasure in doing things?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless?	<input checked="" type="checkbox"/>	<input type="checkbox"/>

If the patient responds "yes" to either questions, follow-up with further assessment for depression.

Rehabilitation Goals

Complete for initial assessment and at least annually

R1. What are the patient's goals (vocational, educational, personal, etc.) for the next year?

For the next 5 years?

Self-Management & Level of Participation in Care

Complete for initial assessment only

SM1. On the following items, indicate the patient's level of understanding:

	Not Able	Limited	Adequate	Excellent
Chronic kidney disease	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treatment options	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis vascular access options	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SM2. Was the patient referred to a pre-dialysis education program or session?

Yes No

SM2a. If yes, did the patient attend the program or session?

Yes, location:

No, reason:

Complete for each assessment (EXCEPT FOR INITIAL ASSESSMENT)

SM3. Patient Interview

Say to the patient: *“Over the past month, how easy or difficult has it been for you to do any of the following?”* Read the options to the patient.

	N/A	Very Easy	Somewhat Easy	Neither Easy nor Difficult	Somewhat Difficult	Very Difficult
1. Come to each hemodialysis treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Complete the full-prescribed hemodialysis treatment time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Perform every peritoneal dialysis treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Take medications as prescribed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Follow dietary restrictions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Follow fluid restrictions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

SM3a. For anything that was SOMEWHAT or VERY DIFFICULT, what would be helpful:

SM4. Does the patient assist with self-care (putting in/taking out own needles, setting up machine, etc.).

- Not permitted in facility
- Yes
- No

SM5. What is the percentage of treatments missed in the last 30 days? (Disregard treatments missed due to hospitalization/travel/or other where treatment was received in another setting)

Percentage:

SM6. What is the percentage of shortened treatments in the last 30 days?

Percentage:

SM7. Does the patient take responsibility for following their medication schedule?

- Yes
- No (If no, check one of the following)
 - Relies on caregiver/support partner to administer medications
 - Not interested
 - Other:

SM8. Does patient appear comfortable asking staff/physician questions?

- Yes
- No
- N/A

SM8a. If NO, what factors limit the patient's comfort in asking questions?

- Does not know what questions to ask
- Cannot speak
- Does not speak English or any language staff speak
- Cognition
- Thinks asking questions is disrespectful
- Other:

SM9. How does patient express concerns/complaints?

Preferences in Home Dialysis³

Complete for each assessment

HD1. Did the patient initiate dialysis AT YOUR FACILITY within the last 12 months?

Yes No Unknown

HD1a. If yes, did the patient's nephrologist or dialysis team provide information about home dialysis (home hemodialysis and PD) within the first 30 days of treatment?

Yes No Patient doesn't recall

HD2. Has the patient been dialyzing at your facility for MORE than 12 months?

Yes No

HD2a. If yes, did the patient's nephrologist or dialysis team provide information about home dialysis (home hemodialysis and PD) within the last 12 months?

Yes No Patient doesn't recall

HD3. Does the patient want to pursue home dialysis?

Yes

No (specify why)

Unsuitable home situation

Medical complication

Satisfied with in-center hemodialysis

Other:

Undecided (specify why):

HD4. Has the patient expressed interest in learning more about home dialysis options?

Yes

No

Comments:

Interest and Suitability for Transplant⁴

Complete for initial assessment and at least annually

T1. Did this patient initiate dialysis AT YOUR FACILITY within the last 12 months?

Yes No

T1a. If yes, did the patient's nephrologist or dialysis team provide information about how to get a transplant within the first 30 days of treatment?

Yes No Patient doesn't recall

T2. Has the patient been dialyzing at your facility for MORE than 12 months?

Yes No

T2a. If yes, did the patient's nephrologist or dialysis team provide information about how to get a transplant within the last 12 months?

Yes No Patient doesn't recall

T3. Does the patient want to be evaluated for a kidney transplant?

Yes No Undecided

T3a. If no, specify:

- | | |
|--|--|
| <input type="checkbox"/> Financial barrier | <input type="checkbox"/> Medical complication |
| <input type="checkbox"/> Age | <input type="checkbox"/> Satisfied with dialysis |
| <input type="checkbox"/> Other: | |

T4. Are there any contraindications to referring patient for transplant evaluation?

T4a. If yes, contraindication identified by:

Transplant center Dialysis facility

Specify contraindication(s) (as indicated by the transplant centers selection criteria):

T5. Has the patient been referred to a transplant center for an evaluation?

Yes No Unknown

T5a. If yes, specify date / /

Specify who referred patient:

- | | | |
|--|--|---------------------------------|
| <input type="checkbox"/> Nephrologist | <input type="checkbox"/> Social worker | <input type="checkbox"/> Nurse |
| <input type="checkbox"/> Patient self-referral | <input type="checkbox"/> Secretary | <input type="checkbox"/> Other: |

Specify how patient was referred:

- Written communication (letters, standard form, email)
 Phone call
 Other:

T5b. If no, specify reasons for not referring:

- | | |
|---|--|
| <input type="checkbox"/> Contraindication(s) | <input type="checkbox"/> Patient already on the waitlist |
| <input type="checkbox"/> Physician judgment or refuses to refer | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Patient not interested/undecided | <input type="checkbox"/> Other: |

Notes and Citations

- 1 These are additional recommended assessment questions regarding Spirituality.
Do you consider yourself to be a religious or spiritual person?
What things do you believe in that give meaning to your life?
How might your beliefs influence your behavior during this illness?
What role might your beliefs play in helping you with your kidney disease?
What can your dialysis team do to support spiritual issues in your health care?
Is there a person or group of people who can help support you in your illness?
- 2 These questions were modified from questions on the CMS Long Term Care Resident Assessment Instrument Version 3.0 of the MDS (Minimum Data Set) which can be located at the following Web site: [http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp - TopOfPage](http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp-TopOfPage). The Confusion Assessment Method (CAM) is included in the MDS draft and is a standardized assessment tool. For additional information regarding the use of a CAM, see the following Web site as a resource: http://hospitalelderlifeprogram.org/pdf/The_Confusion_Assessment_Method.pdf. If a facility or social worker chooses to use the tool or another version of the CAM, it is the responsibility of the user to research and comply with any copyright requirements.
- 3 The questions regarding "Preferences in Home Dialysis" should be complimented by the use of the METHOD TO ASSESS TREATMENT CHOICES FOR HOME DIALYSIS" (MATCH-D) TOOL (available <http://www.homedialysis.org/files/pdf/pros/MatchD2007.pdf>)
- 4 Taken with permission from the following: ESRD Special Study: Developing Dialysis Facility-Specific Kidney Transplant Referral Clinical Performance Measures, performed under Contract Number 500-03-NW09, entitled "End-Stage Renal Disease Network Organization Number 9", sponsored by the Centers for Medicare & Medicaid Services, Department of Health and Human Services. <http://www.therenalnetwork.org/images/TransTEPfinalrpt805.pdf>
- 5 These questions come from the Alcohol Use Disorders Identification Test (AUDIT) which is a free assessment tool developed by the UN Whole Health Organization. The assessment tool may be administered as an interview or as a questionnaire. The tool comes in both Spanish and English. A PDF version of the tool and manual is available for download at http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf.
- 6 The PHQ-2 is derived from the Physicians Health Questionnaire (PHQ-9), which is copyrighted, and is available in English and Spanish. To read about the PHQ-9, locate scoring instructions and register for download go to <http://www.depression-primarycare.org/clinicians/toolkits/> or <http://www.phqscreeners.com/>.
- 7 One example of a fall risk assessment can be found in the following reference. *Tinetti, M.E., Williams, T.F., Mayewski, R. (1986). Fall risk index for elderly patients based on number of chronic disabilities. American Journal of Medicine, 80, 429-434.*

- 8 An excellent reference for nephrology nursing standards and guidelines is the *Nephrology Nursing Standards of Practice and Guidelines for Care* (2005) edited by Sally Burrows-Hudson and Barbara Prowant. It is available from the American Nephrology Nurses' Association <http://www.annanurse.org>.
 - 9 The Centers for Disease Control and Prevention have current immunization recommendations for children and adults available on their Web site <http://www.cdc.gov/vaccines>.
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The Conditions for Coverage for End-stage Renal Disease Facilities were published April 15, 2008 by the Department of Health and Human Services, Centers for Medicare & Medicaid Services

To go into effect **October 14, 2008**

You can find the entire conditions for coverage at:

<http://edocket.access.gpo.gov/2008/pdf/08-1102.pdf>