

DIALYSIS, VACCINATION, AND MEDICAL INFORMATION

You are the most important member of your healthcare team. You and your family members or care partners can use this form to keep track of your vaccinations and medications, so that you have a complete list to share with all of your healthcare providers. Bring this form with you to appointments with your doctors, hospitals and dialysis clinic, and work with your healthcare team to keep all of your information up to date.

MY INFORMATION

My Name: _____

Phone: _____

Emergency Contact

Name: _____

Phone: _____

DOCTORS

Name: _____

Phone: _____

Name: _____

Phone: _____

Name: _____

Phone: _____

Name: _____

Phone: _____

VACCINATIONS

Pneumonia Date: _____

Clinic: _____

Phone: _____

Hepatitis B Dates:

First: _____ Second: _____ Third: _____

Booster: _____ Antigen: _____

Clinic: _____

Phone: _____

Flu Date: _____

Clinic: _____

Phone: _____

SPECIAL NEEDS (Describe)

PHARMACIES

Name: _____

Phone: _____

Name: _____

Phone: _____

ALLERGIES

DIALYSIS

Type of Dialysis: _____

Dialysis Clinic: _____

Phone: _____



Better healthcare,
realized.

To file a grievance, please contact us:

IPRO End-Stage Renal Disease Network of the South Atlantic

909 Aviation Parkway, Suite 300, Morrisville, NC 27560

Patient Toll-Free: (800) 524-7139 • Main: (919) 463-4500 • Fax: (919) 388-9637

E-mail: info@nw6.esrd.net • Web: network6.esrd.ipro.org

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