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 then 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

- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Secondary hyperparathyroidism
- ☐ Vitamin D insufficiency or deficiency
- ☐ Parathyroidectomy
- ☐ Diabetes mellitus
  - ☐ Type I
  - ☐ Type II
  - ☐ Diet-controlled
  - ☐ Insulin-controlled
  - ☐ Self-monitoring

Explanations:

N4. Gastrointestinal Disorders ☐ N/A

- ☐ Constipation
- ☐ Poor appetite
- ☐ Diverticulosis
- ☐ Esophageal disorders
- ☐ Gastroparesis
- ☐ Peptic ulcer disease
- ☐ GI disease
- ☐ Diarrhea
- ☐ Nausea
- ☐ GERD (gastroesophageal reflux disease)
- ☐ Dysguesia
- ☐ GI bleeding
- ☐ Feeling of fullness (PD patients)
- ☐ Liver transplant

Specify:

Explanations:

N5. Neurological Disorders ☐ N/A

- ☐ Seizure disorder
- ☐ CVA (stroke)
- ☐ Carpal tunnel syndrome
- ☐ Restless leg syndrome
- ☐ TIA (transient ischemic attacks)
- ☐ Dysphagia
- ☐ Peripheral neuropathy
- ☐ Parkinson's disease

Explanations:

N6. Musculoskeletal ☐ N/A

- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Fractures (explain below)
- ☐ Gout
- ☐ Back Injury
- ☐ Rheumatoid arthritis
- ☐ Metabolic bone disease of CKD
- ☐ Joint replacements
- ☐ Fibromyalgia

Explanations:

N7. Genitourinary ☐ N/A

- ☐ Residual urine
  - Volume/day:
- ☐ Prostate issues
- ☐ Painful urination
- ☐ Gynecological issues
- ☐ 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 ☐ Chronic Hepatitis B
☐ Acute Hepatitis C ☐ Chronic 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 **u**lcers 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 ☐ Heparin allergy
☐ Bleeding disorder ☐ Heparin–induced thrombocytopenia
☐ Other
Explanations:

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

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

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:
☐ Cramping ☐ Nausea
☐ Hypertension ☐ Hypotension
☐ Dizziness ☐ Hypoxemia
☐ 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 AIC:
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
- ☐ Bicycling
- ☐ Conditioning or weight training
- ☐ Jogging
- ☐ Swimming
- ☐ 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 (phychotropics/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	
	☒	Not able to communicate in English *Requires interpretation assistance at all times*
	☒	Only able to communicate basic needs to staff *Uses single words or short phrases – requires interpretation assistance for conversations and care planning*
	☐	Able to communicate with staff in most situations *Able to carry on conversations with staff. Requires occasional interpretation assistance for more complex conversations*.
☐		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)

☐	Family
☐	Friends and/or other social supports
☐	Professional interpreter
☐	Community agency
☐	Facility staff (able to communicate with the patient in their primary language)
☐	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
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	

Advance Care Planning

Complete for each assessment

AP1. Does patient have any of the following?

	Yes	No	Copy at Facility	
Advance Directive (*living will, durable power of attorney for healthcare, and health care proxy*)	☐	☐	☐	Appointee:
Do Not Resuscitate Order at Facility	☐	☐	☐	
Do Not Resuscitate Order in Community	☐	☐	☐	
Court Appointed Guardian	☐	☐	☐	Appointee:
Durable Power of Attorney for Financial	☐	☐	☐	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
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
☐ 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)

☐	Walk	☐	Taxi (Self-pay)
☐	Drives self	☐	ADA transport
☐	Public bus	☐	Insurance funded transport
☐	Family	☐	Other:
☐	Friends	☐	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
☐ Employed full-time	☐ Employed full-time
☐ Employed part-time	☐ Employed part-time
☐ Retired	☐ Retired
☐ Medical leave of absence	☐ Medical leave of absence
☐ Not employed - by choice	☐ Not employed - by choice
☐ Not employed - looking for work	☐ Not employed - looking for work
☐ Not employed - disabled	☐ 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.)	☐	☐	☐
Food	☐	☐	☐
Medication	☐	☐	☐
Utilities	☐	☐	☐
Housing/Rent	☐	☐	☐
Legal	☐	☐	☐
Immigration	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐

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

- ☐ Independent
- ☐ Assistance required: (Indicate activities requiring assistance)
  - ☐ Bathing
  - ☐ Toileting
  - ☐ Dressing
  - ☐ Medication management
  - ☐ Meal preparation
  - ☐ Housekeeping
  - ☐ Laundry
  - ☐ Transportation
  - ☐ Shopping
  - ☐ Finances
  - ☐ Medical appointments
  - ☐ Other:
- ☐ 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?
- ☐ Owns home/condo/mobile home
- ☐ Rents apt/house
- ☐ Assisted living
- ☐ Public housing
- ☒ Long-term care facility (nursing home)
- ☒ Acute rehabilitation center
- ☒ Shelter
- ☐ Correctional facility
- ☒ Homeless
- ☒ Adult family home/group home

Support System & Spirituality[1]

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

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
	☐ Yes ☐ No	☐	☐	☐	☐
	☐ Yes ☐ No	☐	☐	☐	☐
	☐ Yes ☐ No	☐	☐	☐	☐
	☐ Yes ☐ No	☐	☐	☐	☐
	☐ Yes ☐ No	☐	☐	☐	☐
	☐ Yes ☐ No	☐	☐	☐	☐

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	☐	☐	☐	☐
Decreased interest/pleasure in most activities	☐	☐	☐	☐
A problem with appetite/weight change	☐	☐	☐	☐
Significant sleep disturbance	☐	☐	☐	☐
Psychomotor retardation or agitation	☐	☐	☐	☐
Fatigue, loss of energy	☐	☐	☐	☐
Feelings of worthlessness or guilt	☐	☐	☐	☐
Poor concentration	☐	☐	☐	☐
Suicidal ideation	☐	☐	☐	☐
Panic attacks	☐	☐	☐	☐
Irritable mood	☐	☐	☐	☐
Early awakening	☐	☐	☐	☐

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
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

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?	☒	☐
2. Feeling down, depressed, or hopeless?	☒	☐

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	☒	☒	☐	☐
Treatment options	☒	☒	☐	☐
Dialysis vascular access options	☒	☒	☐	☐

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.	☐	☐	☐	☐	☐	☐
2. Complete the full-prescribed hemodialysis treatment time.	☐	☐	☐	☐	☐	☐
3. Perform every peritoneal dialysis treatment.	☐	☐	☐	☐	☐	☐
4. Take medications as prescribed.	☐	☐	☐	☐	☐	☐
5. Follow dietary restrictions.	☐	☐	☐	☐	☐	☐
6. Follow fluid restrictions.	☐	☐	☐	☐	☐	☐

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 Dialysis [3]

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 Transplant [4]

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:
☐ Financial barrier ☐ Medical complication
☐ Age ☐ Satisfied with dialysis
☐ 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:
☐ Nephrologist ☐ Social worker ☐ Nurse
☐ Patient self-referral ☐ Secretary ☐ Other:

Specify how patient was referred:
☐ Written communication (letters, standard form, email)
☐ Phone call
☐ Other:

T5b. If no, specify reasons for not referring:
☐ Contraindication(s) ☐ Patient already on the waitlist
☐ Physician judgment or refuses to refer ☐ Unknown
☐ Patient not interested/undecided ☐ Other:

General Narrative Comments:

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. 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.

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