ESRD LONG TERM PROGRAM (LTP)

Patient Name: Date:
Facility Name: Last LTP Date:

Primary Diagnosis: • If Diabetic, Type I_____ or Type II______ • Peak Serum Cr prior to initiation of dialysis: ______ Date:	Secondary Diagnosis:
Transplant Center: (if applicable)	Home Training Center: (if applicable)

<u>Long Term Dialysis Modality Plan</u>
(CIRCLE CURRENT MODALITY AS APPLICABLE)

Date of 1st Dialysis:_________ Date of 1st dialysis at this facility:___________

1. In center hemodialysis: a. Self b. Staff-assisted
2. Home hemodialysis
3. In Center Peritoneal Dialysis: a. Self b. Staff-assisted
4. Home Peritoneal Dialysis a. CAPD b. CCPD c. IPD

<u>Patient is not a Home Dialysis candidate because:</u>
(CIRCLE ALL APPLICABLE; COMPLETE IF DIFFERENT THAN LAST LTP)

1. Medically unsuited. Specify:____
2. Psychologically unsuited. Specify:____
3. Unsuitable home situation.
4. No suitable partner.
5. Refused home training.
6. Other. Specify:____

<u>Long Term Transplant Modality Plan</u> **<u>(CIRCLE ONE)</u>**

1. Living related donor
2. Living unrelated donor
3. Cadaver donor
4. Not yet known. DATE:______________
5. Not a candidate secondary to permanent exclusionary criteria as established by transplant center.
6. Not a candidate at present. SPECIFY on next page.

Patient is not a transplant candidate at present because: **(CIRCLE ALL APPLICABLE)**

1. Medically unsuited. SPECIFY:____
2. Psychologically unsuited. SPECIFY:____
3. Evaluation in progress: (DATE):____
4. Not interested. REASON GIVEN:____
5. Other. SPECIFY:____

<u>Rehabilitation Status</u>

1. Employed Full-Time
2. Employed Part-Time
3. Homemaker
4. Medical Retirement/Disabled
5. Normal age retirement
6. Student
7. Pre-school child
8. Unemployed

If unemployed: **(CIRCLE ALL APPLICABLE)**

1. Temporarily unemployed (seeking work or on leave of absence)
2. Rejected from employment due to illness.
3. Needs vocational rehabilitation training.
4. Referred / Enrolled in vocational rehabilitation training. DATE:_________________
5. No interest in vocational rehabilitation training.

<u>Multi-disciplinary ESRD Team Individualized Comments as Indicated:</u>

PHYSICIAN:____

____

______________________________________Signature & Date:______________________________

TRANSPLANT SURGEON or DESIGNEE:____

____

______________________________________Signature & Date:______________________________

NURSING:____

____

______________________________________Signature & Date:______________________________

DIETICIAN:____

____

______________________________________Signature & Date:______________________________

SOCIAL WORKER:____

____

______________________________________Signature & Date:______________________________

PATIENT OR PATIENT REPRESENTATIVE:____

____

______________________________________Signature & Date:______________________________