National Kidney Foundation™
of Arizona

# Nutritional Supplement Application

**Date**

Month Day Year

**Is the patient participating in the nutritional supplement study?**

- ◯ Yes
- ◯ No

**Has the patient signed the consent form?**

- ◯ Yes
- ◯ No

**Patient Name**

First Name Last Name

**Patient Date of Birth**

Month Day Year

**Is the patient pregnant in the second or third trimester?**

- ◯ Yes
- ◯ No

**Is the patient a smoker?**

- ◯ Yes
- ◯ No
- ◯ Quit at least 6 months ago



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**Has the patient been admitted to a hospital with an overnight stay in the last 30 days?**

- ◯ Yes
- ◯ No

**Name of Nephrologist**

First Name Last Name

**Treatment Facility**

**Dietitian Name**

First Name Last Name

**Dietitian Email**

example@example.com

**Social Worker Name**

First Name Last Name

**Has the patient exhausted available support resources such as private insurance, AHCCCS/ALTCS or the Southwest Center for HIV/AIDS?**

**If Yes, Please check all that apply**

- ☐ Insurance
- ☐ AHCCCS/ALTCS
- ☐ Southwest Center for HIV/AIDS
- ☐ Other

**Is this a refill order?**

- ◯ Yes
- ◯ No

**What was the original qualifying lab/weight value?**



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**What is the patient's current Albumin g/dl?**

**What is the patient's current nPCR (normalized protein catabolic rate)?**

Enter 0 if no data is available

**Patient % Standard Body Weight**

**Has the patient experienced greater than 7.5%undesirable weight loss in the past 90 days?**

- ◯ Yes
- ◯ No

**Has the patient experience greater than 10% undesirable weight loss in the past six months?**

- ◯ Yes
- ◯ No

**Has the patient experienced weight gain less than 0.3 kg/week?**

- ◯ Yes
- ◯ No

**Has the patient experienced no weight gain over a 3 month period or any amount of undesirable weight loss over 2 months?**

- ◯ Yes
- ◯ No

**Patient Height (in inches)**

**Is Patient an amputee?**

- ◯ Yes
- ◯ No

**Type of amputation?**



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- ◯ AKA
- ◯ BKA
- ◯ Other

**If Other, please explain**

**Type of dialyisis**

- ◯ Hemo
- ◯ PD

**Dialysis Vintage**

- ◯ < 30 days
- ◯ 30 - 90 days
- ◯ 3 months to 1 year
- ◯ 1 - 3 years
- ◯ > 3 years

**Cause of renal failure**

- ☐ DM
- ☐ HTN
- ☐ PKD
- ☐ Lupus
- ☐ Unknown
- ☐ Other

**Patient Comorbidities (Mark all that apply)**

- ☐ Diabetes - Type 1
- ☐ Diabetes - Type 2
- ☐ Hypertension
- ☐ Polycystic Kidney Disease
- ☐ CVD
- ☐ Cirrhosis
- ☐ CA
- ☐ Other


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**Does the patient take in-center supplements at dialysis?**

- ◯ Yes
- ◯ No

**In months, how much longer do you anticipate supplements will be taken?**

**Do you believe this patient will need long term supplementation?**

- ◯ Yes
- ◯ No

**90 Day History**

**EDW (kg) (Current)**

**EDW (kg) (Prior Month)**

**EDW (kg) (Two Months Ago)**

**Albumin (Prior Month)**

**Albumin (Two Months Ago)**

**nPCR (Prior Month)**



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**nPCR (Two Months Ago)**

**Package Selection**

**Zone Perfect Bar Flavor Selection**

- ◯ Chocolate Mint
- ◯ Cinnamon Roll
- ◯ Fudge Graham
- ◯ Strawberry
- ◯ Variety Pack

**Ensure Clear Flavor Selection**

- ◯ Apple
- ◯ Berry

**Liquacel 32 oz Flavor Selection**

- ◯ Grape
- ◯ Orange
- ◯ Peach Mango
- ◯ Lemon

**Liquacel Single Serve Packet Flavor Selection**

- ◯ Grape
- ◯ Peach Mango
- ◯ Lemon

**Nepro Flavor Selection**

- ◯ Butter Pecan
- ◯ Mixed Berry
- ◯ Vanilla

**Procel Flavor Selection**

- ◯ Vanilla



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**Suplena Flavor Selection**

◯ Vanilla

Submit



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National Kidney Foundation™
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# Patient Financial Profile

CONFIDENTIAL

**Patient's Name** *

First Name Last Name

**Patient Date of Birth**

Month Day Year

**Phone Number**

Area Code Phone Number

**Date of Transplant**

Month Day Year

**Date of First Dialysis Treatment**

Month Day Year

**Insurance Information**

- ☐ Private Insurance
- ☐ AHCCCS.
- ☐ Medicare
- ☐ VA Coverage
- ☐ No Coverage



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## Insurance Carrier Name

## Insurance Expiration Date

Month Day Year

## Treatment Facility

## Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

## How long at current address?

## Home is:

- ◯ Rented
- ◯ Owned



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**Name and address of Landlord (rented) or Leinholder (own)**

**Marital Status**

**Number of Dependents**

**Household is less than 400% Federal Poverty Level (see chart below)**

- ◯ Yes
- ◯ No

Household size (number living there) / 400% Federal Poverty Guidelines

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|
| $47,520 | $64,080 | $80,640 | $97,200 | $113,760 | $130,320 | $146,920 | $163,560 |

## Demographic information is often required to obtain grant funding for patient programs.

This is optional, but greatly appreciated.

**Patient Ethnicity (Please choose one)**

**Is patient of Hispanic descent? (Please choose one)**



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**Patient is an enrolled member of the following tribal community, village, reservation or nation:**

Please select all that apply

**Date**

Month Day Year

**Unit Representative Name**

First Name Last Name

**Position**

**Date**

Month Day Year

Submit



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