Supplemental Kidney Medical Form
Must be completed by a Nephrologist Only

Dear Medical Provider,
The camper listed below has applied to attend camp at The Painted Turtle during one of our Kidney Disease and Transplant sessions. In order to consider their application we need the following information completed and returned to The Painted Turtle as soon as possible.

Please return all completed forms to:
Email: admissions@thepaintedturtle.org
Fax: 661-724-1566
If there are any questions about this form or camper, please feel free to contact our Medical Team at (661) 724-1768.

Camper Name: _____ DOB _____ Child's Weight (kg): _____

Check all that apply: ☐ General Nephrology ☐ Transplant ☐ Peritoneal Dialysis ☐ Hemodialysis

Renal Information

Date camper was last seen by medical team: _____ Primary Renal Diagnosis: _____

Treatment Center Name: _____ Treatment Center Phone: _____

Most Recent Lab values:

****** Labs will need to be checked again before camp within:**

- **Six (6) months of camp for General Nephrology campers**
- **One month of camp for Post Transplant campers if transplant within last 6 months; within 3 months of camp if transplant >6 months before camp.**
- **Two Weeks of camp for Hemodialysis and Peritoneal Dialysis campers**

Please fax all labs to 661-724-1566

Most **recent laboratory values:** Date labs drawn _____ (May attach a lab result summary)

Hgb _____ Hct _____ Cr _____ BUN Pre _____ BUN Post _____ K _____ CO2 _____ Ca _____ PO4 _____ Na _____

*****Please attached most recent clinic note and/or discharge summary.*****

Transplant Information (Complete if applies to the camper listed above)

Date of Transplant: _____ Secondary Condition(s): _____

Rejection episode in past 6 months: ☐ Yes ☐ No If yes, date and treatment _____

Is camper a multi organ transplant (i.e. kidney + heart or liver)? ☐ Yes ☐ No

_____

Physician's Signature: _____ Date: _____

Peritoneal Dialysis Information Form (If applicable)

Camper Name: _____ DOB _____

Peritoneal Dialysis Information

☐ CAPD ☐ CCPD Date started dialysis: _____ Is child anephric? ☐ Yes ☐ No Child's Dry Weight (kg): _____

Dialysis Unit Name: _____ Phone _____ Fax _____

Name of Cycler: _____ Name of Catheter Cap: _____

Ex Vol (cc) _____ Ex Every (hours) _____ # exchanges _____ Total Vol _____

Total Number of Hours/Night _____ Last Fill Vol _____ Dextrose Concentration Used _____

Mid-day exchange: ☐ Yes ☐ No If yes: time of exchange (am/pm): _____ Volume (cc): _____ % Dextrose _____

Low Ca + Dialysate _____ Regular Ca + Dialysate _____ 5L bags _____ 6L bags _____

Other: _____

Inflow/Outflow problems: _____

Infection History (within last six months):

Peritonitis: Date: _____ Organism(s): _____ Treatment: _____

Exit Site: Date: _____ Organism(s): _____ Treatment: _____

Tunnel: Date: _____ Organism(s): _____ Treatment: _____

Physician's Signature: _____ Date: _____