

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:

**Please fax all labs to 661-724-1566**

- 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

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: