ESKD Life-Plan

Date Completed:____________________________

Patient Name:

Addressograph

Primary Nephrologist: ____ Phone: ________________________

Primary Interventionalist: ____ Phone: ________________________

Primary Surgeon: ____ Phone: ________________________

Primary Care Practitioner: ____ Phone: ________________________

Emergency Contact: ____ Phone: ________________________

Key Notes: ____

Language(s) Spoken: __________________________________Translator required: ___________________________

Modality 1	→	Modality 2	→	Modality 3
HD		Transplant		HD

Access Strategy	Access Strategy	Access Strategy
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________

I gave input into my ESKD Life-Plan, understand it and agree to it.

I have discussed the RRT options and associated dialysis access strategies with the patient and answered their questions to their satisfaction and understanding

____
Patient signature

____
Health care professional signature

This is an annual update: ☐ Yes ☐ No

Has the ESKD Life-Plan changed since the last review: ☐ Yes ☐ No

If YES, the ESKD Life-Plan has changed, fill out a new ESKD Life-Plan document