NORTHWEST

Pruritus Assessment - Difelikefalin Request

Patient Name: _____ _____ __ DOB: _____

Does your patient have a diagnosis of Uremic Pruritus? (ensure this is documented in NKC EMR) YES NO (ICD10 L29.9)

Has your patient received therapy for uremic pruritus?

UV therapy Improved Symptoms YES NO

Other _____ Improved Symptoms YES NO

Itch ± Description: location, time (e.g. only at dialysis), rash associated

_____ _

_____ _____

Adequate dialysis for last 2 months : YES NO

Worst Itching Over the Past 24 Hours										
Please indicate the worst itching you experienced over the past 24 hours										
0	1	2	3	4	5	6	7	8	9	10
•	•	•	•	•	•	•	•	•	•	•
No itching										Worst itching
				Moderate			Severe			

Score for your patient at minimum on 2 different occasions , optimally more than 24 hours apart. Document dates.

#1 Score: _____ Date: _____

#2 Score: _____ Date: _____

Current opioid use: YES NO; if YES, what is Rx? _____

Does patient have allergy to opioids? YES NO

Physician signature: _____ Date: _____

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Fax to Pharmacy 206 - 343 - 4884 CMO Approv al required: YES NO