HEMODIALYSIS COMMUNICATION

Facility:_____ **Date of Service:**_____

FACILITY COMPLETES THIS INFORMATION

Vital Signs: Pre-Tx: T_____ P_____ R_____ B/P_____ Weight _____kg
Post-Tx: T_____ P_____ R_____ B/P_____ Weight _____kg
Pain: ❍ No ❍ Yes site(s) _____

Vascular Access: ❑ AV Fistula ❑ AV Graft ❑ CV Catheter Site_____
CV Catheter Site - Dressing: Dry & Intact: ❍ No ❍ Yes Caps Intact: ❍ No ❍ Yes ❍ N/A
❑ AV fistula/AV Graft Bruit/Thrill Present: ❍ No ❍ Yes ❍ N/A

Incidents/New Acute Problems Since Last Treatment: (i.e., pain, falls, BP problems, infections, skin tears, ER visit)

_____

Order or Medication Changes: ❍ No ❍ Yes (specify) _____

_____

Complete medication list attached: ❍ No ❍ Yes

Nutritional Concern: ❍ No ❍ Yes (specify) _____

_____

Social Changes: (i.e., death of family member/friend/roommate/transportation concerns, withdraw from dialysis treatment)

_____

Laboratory tests to be drawn at dialysis unit:_____

Additional questions or concerns:_____

_____

_____ _____ _____
Nurse Print Name/Title Nurse Signature Date/Time

DIALYSIS UNIT COMPLETES THIS INFORMATION

Hemodialysis Treatment: Pre-Tx Weight:_____ Pre-Tx B/P:_____ Pre-Tx Temp. _____
Post-Tx Weight:_____ Post-Tx B/P:_____ Post-Tx Temp. _____
Lab Results: ❍ No ❍ Yes ❑ **Copies of Lab Results Attached**

Vascular Access: ❑ AV Fistula/Graft Bruit/Thrill Present: ❍ No ❍ Yes ❍ N/A Post-Tx Bleeding Time:_____
CV Catheter Site - Dressing: Dry & Intact: ❍ No ❍ Yes ❍ N/A Caps Intact: ❍ No ❍ Yes ❍ N/A
PERMANENT ACCESS NOT PRESENT. VASCULAR ACCESS PLAN: ❍ No ❍ Yes ❍ Unknown
Surgeon Name:_____ Vessel Mapping Date:_____ Surgeon Appt: ❍ No ❍ Yes
Surgery Date for Permanent Access Placement:_____ CV Catheter Date:_____ (Planned/Completed)
Date of Vascular Access Insertion:_____

Medications given during dialysis Tx:_____

Occurrence during dialysis Tx: (fever, pain, chills, prolonged bleeding, hypertension, hypotension, increased weakness, etc.)

_____

_____

Physician ordered changes: (dialysis time increased or decreased, change in target dry weight, diet, medication, etc.)

_____

Follow-up includes:_____

_____

_____ _____ _____
Nurse Print Name/Title Nurse Signature Date/Time

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed