HEMODIALYSIS COMMUNICATION FORM

Facility Name: ____ Date: ________________________________

Resident Name: _______________________________________ Age: __________________________________

Primary Diagnosis: ____________________________________ Advance Directives/Code Status: ___________

SECTION 1: Completed by Facility Staff (send with resident to dialysis center)				
Significant change/decline since last dialysis ☐ No ☐ Yes (explain)_________________________				
Fall risk: ☐ No ☐ Yes (explain)____				
Vital Signs: Time observed: _______ Temperature ________ ☐ Temporal ☐ Oral ☐ Axillary ☐ Tympanic B/P: _______________ Pulse: __________ Resp: _______________ Weight: _____________				
Dialysis Access Site				
☐ Redness, if present describe	☐ Drainage, if present describe	☐ Pain/Burning, if present describe	☐ Thrill/Bruit, if absent action taken	☐ Dressing Dry/Intact
Resident Status				
☐ Oriented x3	☐ Confused	☐ Agitated	☐ Sedated/lethargic	☐ Weakness
☐ SOB	☐ Chest Pain	☐ Lung Congestion	☐ Edema	☐ Neck Vein Distention
☐ N/V	☐ Prolonged Bleeding (explain):_____________________________________			
Lab Tests (attach copy if needed): Changes in medication regime since last dialysis treatment		Diet Order/Fluid Restrictions (include resident compliance and I&O regime since last dialysis monitoring		
Current Medications (attach copy if needed): Changes in medication regime since last dialysis treatment:				
Nurse Signature:		Date:		
SECTION 2 (Completed by Dialysis Center and return with resident post dialysis)				
Vital Signs (Pre Dialysis) Temperature ________ Temporal Oral Axillary Tympanic (circle one) B/P: _____ Pulse: ______ Resp: ____ Weight: ______		Vital Signs (Post Dialysis) Temperature ________ Temporal Oral Axillary Tympanic (circle one) B/P: _____ Pulse: ______ Resp: ____ Weight: ______		
Resident Compliance During Dialysis:				
Nutrition Concerns:		Medications Given During Dialysis		
Laboratory Values – circle one and attach copy of current and monthly results Labs Drawn: Yes No				
Post Dialysis Instructions		New Physician Orders		
Resident Status				
☐ Orientated x3	☐ Confused	☐ Agitated	☐ Sedated/lethargic	☐ Weakness
☐ SOB	☐ Chest Pain	☐ Lung Congestion	☐ Edema	☐ Neck Vein Distention
☐ N/V	☐ Prolonged Bleeding (explain) _____________________________________			
Next Dialysis treatment date/time				
Dialysis Nurse Signature:			Date:	
(Print Dialysis Nurse Name)				