

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

<input type="checkbox"/> Redness, if present describe	<input type="checkbox"/> Drainage, if present describe	<input type="checkbox"/> Pain/Burning, if present describe	<input type="checkbox"/> Thrill/Bruit, if absent action taken	<input type="checkbox"/> Dressing Dry/Intact
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Resident Status

<input type="checkbox"/> Oriented x3	<input type="checkbox"/> Confused	<input type="checkbox"/> Agitated	<input type="checkbox"/> Sedated/lethargic	<input type="checkbox"/> Weakness
<input type="checkbox"/> SOB	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Lung Congestion	<input type="checkbox"/> Edema	<input type="checkbox"/> Neck Vein Distention
<input type="checkbox"/> N/V	<input type="checkbox"/> 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

<input type="checkbox"/> Oriented x3	<input type="checkbox"/> Confused	<input type="checkbox"/> Agitated	<input type="checkbox"/> Sedated/lethargic	<input type="checkbox"/> Weakness
<input type="checkbox"/> SOB	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Lung Congestion	<input type="checkbox"/> Edema	<input type="checkbox"/> Neck Vein Distention
<input type="checkbox"/> N/V	<input type="checkbox"/> Prolonged Bleeding (explain): _____			

Next Dialysis treatment date/time

Dialysis Nurse Signature: _____

Date: _____

(Print Dialysis Nurse Name)