

2011 Kappa Kidney Camp



HEMODIALYSIS TREATMENT FORM

To be completed by Dialysis Nurse & signed by a Physician

Name: _____

<p>ACCESS: <input type="checkbox"/> graft <input type="checkbox"/> fistula <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> catheter <input type="checkbox"/> position _____ Problems w/ access: <input type="checkbox"/> NO <input type="checkbox"/> YES, describe _____ _____</p> <p>Needles: <input type="checkbox"/> 15 ga <input type="checkbox"/> 16 ga <input type="checkbox"/> 17 ga Use of: <input type="checkbox"/> EMLA <input type="checkbox"/> Lidocaine <input type="checkbox"/> none</p>	<p>BP Cuff Size: <input type="checkbox"/> child <input type="checkbox"/> adult <input type="checkbox"/> lg. adult <input type="checkbox"/> thigh Avg. Blood Pressure Pre: _____ Post: _____</p>
<p>Time: <input type="checkbox"/> 3 hrs <input type="checkbox"/> 3&1/2 hrs <input type="checkbox"/> 4 hrs <input type="checkbox"/> _____ Blood Flow: _____ mL/min Dialysate: <input type="checkbox"/> 500 <input type="checkbox"/> 600 <input type="checkbox"/> 800 Bath: K+: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 CA±: <input type="checkbox"/> 0 <input type="checkbox"/> 2 <input type="checkbox"/> 3 Na Modeling: <input type="checkbox"/> NO <input type="checkbox"/> YES, describe _____ Dialyzer: _____ Priming Vol: _____ Surface Area: _____ Blood Tubing: <input type="checkbox"/> pediatric <input type="checkbox"/> adult Priming Vol: _____</p>	<p>MEDS GIVEN ON DIALYSIS: <input type="checkbox"/> Heparin Bolus: _____ units Pump: _____ units/hr <input type="checkbox"/> Epogen Dose _____ units. how often _____ <input type="checkbox"/> Zemplar Dose _____ mcg. how often _____ <input type="checkbox"/> Calcijex _____ Dose _____ mcg. How often _____</p>
<p>Dry Wt: Kg. _____ -or- _____ Lbs. Avg. wt gain: _____ Max wt. loss: _____ Other: _____ _____ _____</p>	<p>PROBLEMS ON DIALYSIS: <input type="checkbox"/> cramps <input type="checkbox"/> N/V <input type="checkbox"/> hypotension <input type="checkbox"/> hypertension <input type="checkbox"/> excess fluid gain <input type="checkbox"/> none <input type="checkbox"/> other; describe _____ _____ Corrective action: _____ _____ _____</p>
	<p>Able to eat while on dialysis? <input type="checkbox"/> NO <input type="checkbox"/> YES, describe: _____ _____ _____</p>

Form completed by: _____ Nurse Signature _____ date _____

All the above information is correct: _____ Physician signature _____ date _____