

Kappa Kidney Camp 2009



HEMODIALYSIS TREATMENT FORM

To be completed by Dialysis Nurse & signed by a Physician

Name: _____

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

Form completed by: _____ Nurse Signature _____ date _____

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