

DIALYSIS COMMUNICATION FORM

GLEN HAZEL McKEESPORT ROSS SCOTT

PHONE NUMBER : _____

NURSING UNIT EXTENSION: _____

ADDRESSOGRAPH

TO BE COMPLETED BY NURSING HOME

Vital Signs :

Pre: T _____ P _____ R _____ BP _____
 Post: T _____ P _____ R _____ BP _____

ACUTE PROBLEMS SINCE LAST APPOINTMENT:
 (i.e., falls, skin tear, infections or significant incident)

Vascular Access: (circle) Fistula/Graft Cath. Site _____

Cath. site: Dressing dry & intact Yes No N/A Caps on: Yes No N/A

Fistula/Graft: Bruit/Thrill present: Y N N/A

NEW ORDERS/MEDICATION CHANGES: _____ NO _____ YES (if yes, list below) Full Medication list attached Y N

DIETARY CONCERNS: _____ NO _____ YES (if yes, describe in detail)

SIGNIFICANT SOCIAL CHANGES: (i.e., death of family member/roommate, request to withdraw from treatment, transportation issues)

Physician ordered laboratory tests requested to be done during dialysis: _____

Other Comments: _____

NURSE PRINT NAME _____

SIGNATURE _____

DATE _____

TO BE COMPLETED BY DIALYSIS UNIT

DIALYSIS TREATMENT:

Pre-Weight: _____ Kg Pre-BP _____ Temp: _____

Post-Weight: _____ Kg Post-BP _____ Temp: _____

Fistula/Graft: Bruit/Thrill present: Y N N/A Bleeding time: _____

Cath. site : Dressing dry & intact Yes No N/A Caps on: Yes No N/A Date inserted _____

If Cath.: Vascular Access Plan: Y N Unknown Cath. removal _____

Vessel mapping/Date _____ Surgeon appt. Y N Surgery date _____

Comment: (Specifically about fever, chills, hypertension, excessive weakness, prolonged bleeding from needle sites, unusual complications or occurrences)

MEDICATIONS GIVEN DURING DIALYSIS: _____

Procedural/Changes: (i.e., dialysis duration, change target weight, medication, diet)

RECOMMENDATIONS FOR FOLLOW-UP: Y N _____

Labs: Y N DATE and LAB tests done: _____ ATTACH COPIES OF LAB RESULTS

SIGNATURE _____

DATE _____

TITLE _____

PHONE NUMBER AND EXTENSION _____