UNIVERSITY MEDICAL CENTER

PATIENT PROGRESS RECORD
ACUTE HEMODIALYSIS UNIT

Date: _____ Patient Name _____ MR# _____

	PRE TX	POST TX
BP SIT		
BP STAND		
PULSE		
TEMP		
PAIN INTENSITY SCORE		
WEIGHT (KG.)		
PREV POST WEIGHT		
GAIN		
LOSS	ML OFF	

TREATMENT ORDERS

Dialyzer:
Dialysate: _____ K+ _____ Ca++
Duration of Tx.:
Sodium Variation:
Bloodflow: Dialysate Flow:
Dialysate Temp. (C°):
Dry Weight (kg):
Target Loss:
Formula ML/HR:
Heparin Initial: _____ units Hourly: _____ units

Lab. Test	HBsAg	HGB	HCT	GLUC	BUN	CREAT	Na	K	CA	PO4
Result:										
Date:										

VASCULAR ACCESS

AV Fistula Graft Side: R / L
Bruit: Pre: _____ Post: _____
CVC Type: _____ Side: R / L

Dialysis Initiated By: Title:
Dialysis Terminated By: Title:

MD Visit: ❑ (Check) Date: _____
Physician Signature_____

TIME	BP	PULSE	BF	ART. PRESSURE	VEN PRESSURE	TMP	HEPARIN BOLUS UNITS IV	ML/HR	IV FLUIDS NS PRIME ML	INITIALS

TIME	BP	PULSE	BF	ART. PRESSURE	VEN PRESSURE	TMP	HEPARIN UNITS IV	ML/HR	IV FLUIDS NS PRIME ML	INITIALS	SUBJECTIVE / OBJECTIVE
TIME TX ENDED:							TOTAL HEPARIN units		TOTAL FLUIDS ml		RINSE BACK

Special Attention:

PAIN INTENSITY SCORE:

0	1-3	4-7	8-10
None	Mild	Moderate	Severe

Hendrich Fall Risk Model - Assessment Tool Score ≥3 Requires Fall Prevention Identification

Risk Factors	Points	Risk Factors (contd.)	Points
Recent History of Falls	+7 PT eval/screen	Dizziness/Vertigo	+3 PT eval/screen
Depression	+4	Poor Judgement	+3
Altered Elimination	+3	Poor Mobility/Generalized Weakness	+2
Confusion/Disorientation	+3	TOTAL INITIAL RISK SCORE	

KEY	
0 - 2	Normal/Low Risk
3 - 6	Level 1/High Risk
More than 6 PT eval/screen	Level 2/Extremely High Risk

KEY:
MBW = Monthly Blood Work
BF = Blood Flow
CVC = Central Venous Catheter
TMP = Transmembrane Pressure
DLC = Dual Lumen Catheter

Dialysis Treatment CareMap®

Signature	Title	Initial

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ **MR#** _____

Treatment Date: _____

PROBLEM / NEEDS	DESIRED OUTCOME	MET	NOT MET*
Access	Remains patent/functional throughout treatment		
	Hemostasis achieved < 10min/site		
Treatment Adequacy	**URR > 70%** (Chronic Patient)		
Anemia	**Hgb > 11.0 Gm**		
	T Sat 20-50% Date Done: _____		
	Ferritin 100-800 ng/ml Date Done: _____		
Fluid Management/ Hemodynamic Stability	Pre/Post Weights obtained		
	Achieved fluid removal goal		
	Absence of edema, shortness of breath		
	Vital signs stable throughout treatment		
Infection	No Evidence of Infection		
	Hepatitis B Screening Completed		
Renal Osteodystrophy	**PTH assay 60 - 200 ng/dl** (Checked quarterly) Date Done: _____		
	PO4 2.5 - 5.5 mg/dl		
	Ca/PO4 product < 55		
Electrolyte Imbalance	**K+ 3.5 - 6.0 mEq/L**		
	Na+ > 130mEq/L		
	(Checked monthly)		

PROBLEM / NEEDS	DESIRED OUTCOME	MET	NOT MET*
Nutrition	**Albumin > 3.5 Gm/dl**		
	Verbalizes understanding of diet & fluid restrictions		
Psychosocial	Demonstrates effective coping skills through verbalization of feelings		
Knowledge Deficit Related to Plan of Care	Patient/family verbalizes understanding of diagnosis and plan of care, and participates in decision making		
Pain Management	Denies pain		
Patient Safety	Remains injury free in a safe environment		
Patient/Family Satisfaction	Patient/family verbalizes satisfaction with care		
Mental Status	Alert, oriented Able to communicate needs		

*Requires Progress Note

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# _____

INTERDISCIPLINARY PROGRESS RECORD
ACUTE HEMODIALYSIS UNIT

Admission Date: Admitting Dx:

Indicate date and time of each entry. Print name under signature following each entry.

Date/Time	Discipline/ Department	

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# _____

INTERDISCIPLINARY PROGRESS RECORD
ACUTE HEMODIALYSIS UNIT

Admission Date: Admitting Dx:

Indicate date and time of each entry. Print name under signature following each entry.

Date/Time	Discipline/ Department	

AFFIX PATIENT INFO LABEL HERE

Date: _____

Patient Name _____ MR# _____

EQUIPMENT PREPARATION	INIT	
Fresenius #: _____		
Unit: _____		
Station/Rm # _____		
Portable RO# _____		
Alarm/Pressure Holding Test		
Conductivity / pH		
ASSESSMENT		
Admission Assessment		
Via:		
Discharge Assessment:		
Via:		
VASCULAR ACCESS		
Cannulation, Routine		
Cannulation, Complex		
Needle Size _____		
Site Assessment (Note Area):		
Central Venous Catheter		
Mfr _____ Type _____		
Insertion Site (Note Area):		

INFECTION	INIT	
Isolation Precautions 1:1		
Organism:		
TREATMENT/LABS		
Heparin Free Protocol		
Cardiac Monitor		
Suction: Oral		
Oxygen: Via:		
Pressure to Site: Self		
Nurse		
Post - Tx Bleeding Time: _____ mins/site		
Blood Sugar: _____ mg/dl		
Specimen Collection (List):		
COMPLICATIONS		
Dysfunctional/Non-Functional Access		
(See Notes)		
Clotted Dialyzer x _____		
Code Blue / Outcome:		

MEDICATIONS			INIT	TIME
Med	**Dose**	**Route**		
Blood Products:				
SELFCARE DEFICIT				
Emesis _____ #x1				
Bowel/Bladder with Assist				
Incontinent Care _____ #x1				
Feeds Self with Help				
Total Feeding By Self				

FULL SIGNATURE	PRINT NAME	INIT	TITLE

Patient Name _____ MR# _____