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HEMODIALYSIS ORDER SHEET

PATIENT IDENTIFICATION

NAME:		Treatment DATE:		BLOOD WORK	PRE	POST
# of HOURS OF HEMODIALYSIS:		# of HOURS OF HEMOFILTRATION:		CBC		
SALINE PRIME GIVEN: <input type="checkbox"/> Yes <input type="checkbox"/> No		DIALYZER:		Hgb / Hct		
BLOOD FLOW RATE				Renal Function		
				Basic Met.		
150 ML:		250 - 300 ML:		BUN		
200 ML:		325 - 350 ML:		Creatinine		
225 ML:		400 - 450 ML:		Glucose		
DIALYSATE				PT		
				PTT		
				Other		
				Magnesium		
				Comprehensive Met.		
2.5 K:	2.0 K:	1.0 K:	K Additive to Raise K to:			
ADDITIONAL ORDERS:						
HEPARINIZATION						
1000 UNITS:	2000 UNITS:	3000 UNITS:	OTHER:			
ULTRAFILTRATION						
Desired TMP of			OR	KGS TO BE REMOVED		
TREATMENT FOR HYPOTENSION						
NORMAL SALINE:	GIVE UP TO:	ML's to maintain Systolic BP:	THAN	ALBUMIN: (50ml) 12.5gms%:	GIVE UP TO:	ML's to maintain Systolic BP:
CRAMPS						
NORMAL SALINE:	GIVE UP TO:	ML'S	HYPERTONIC NACL 23.4%:	GIVE:	ML'S at a Time	UP TO: ML'S Total
					DEXTROSE 50% IV:	AMPS
SIGNATURES						
PHYSICIAN SIGNATURE:		DATE:	TIME:	RN SIGNATURE / TITLE:		DATE: TIME: