UNIVERSITY MEDICAL CENTER

PATIENT PROGRESS RECORD CHRONIC HEMODIALYSIS UNIT

ate:								Patient Na	ime		MK#
	PRE TX	POST TX		REATME	ENT ORDEI	RS				VASCULAR A	CCESS
BP SIT			Dialyzer:					AV Fistu	ıla	Graft	Side: R / L
BP			Dialysate: _	K	(+	Ca++		Bruit: F	Pre:	Post:	
STAND			Duration of	Tx.:							
PULSE			Sodium Var	iation:				CVC Typ	pe:		Side: R / L
TEMP			Bloodflow:	Di	alysate Flo	W:					
PAIN NTENSITY SCORE			Dialysate Te	emp. (C°):			Dialysis	_		
VEIGHT (KG.)			Dry Weight	(kg):				Initiated	Ву:		Title:
PREV POST WEIGHT			Target Loss								
GAIN			Formula ML					Dialysis			
LOSS		ML OFF	Heparin Initi		unite Hourly	./*	ınite	Terminat	ted By:		Title:
TIME	BP F	ULSE BF	ART. VI PRESSURE PRES		P HEPARIN BOLUS UNITS IV			INITIALS	MD Visit:	(Check)	Date:
			THEOGOTIE THEO	JUNE	UNITSIV		ML		Physician Signature	,	
TIME	BP F	PULSE BF	ART. VI PRESSURE PRES	EN TM	P HEPARIN UNITS IV	ML/HR	V FLUIDS NS PRIME	INITIALS	Signature	SUBJECTIV	E / OBJECTIVE
The state of			THEODOILE THEO	OUNE	OMITS IV		IVIL	The state of the state of			
										(
	:										
								1 450			
			-								
IME TX NDED:					TOTAL HEPARIN	F	OTAL LUID		RINSE BACK	,	
Specia	Attentic	n:			units		m				
			,								
PAIN IN	TENSITY SCOF 1-3	RE: <u>Hendrich</u> Risk Fac	<i>Fall Risk Mode</i> tors		<i>ment Tool</i> Risk Factors		Require	s Fall Prev Points	ention Identifi	cation KEY	KEY: MBW = Monthly Blood Work
None		Recent His	tory of Falls +7 P	T eval/screen	Dizziness/Vertigo)	+	.3 PT eval/screen	10 - 2	Normal/Low Risk	BF = Blood Flow
4-7	8-10	Depression			Poor Judgement			+3	3 - 6	Level 1/High Risk	
Modera		Altered Elii Confusion	nination Disorientation		Poor Mobility/Ge TOTAL INITIAL			+2	More than 6 PT eval/s	Level 2/Extremely High Risk	DLC = Dual Lumen Catheter
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Patient Name

MR#

AFFIX PATIENT INFO LABEL HERE

Patient Name	MR#	

EQUIPMENT PREPARATION INIT	VASCULAR ACCESS	INIT		MEDICATIONS	INIT	TIME
Fresenius #:	Central Venous Catheter		Med	Dose Route		
Station #	Mfr: Type:		,	(circle)		
Section: A B C (circle)	Insertion Site (Note Area)		Epogen	/ units SC/IV		
Alarm/Pressure Holding Test			Calcitriol	/ mcg IV		
Conductivity / pH			Zemplar	/ mcg IV		
						,
ASSESSMENT	INFECTION CONTROL					
Admission Assessment	Isolation Precautions 1:1					
Via:	Organism:					
Discharge Assessment:						
Via:						
VASCULAR ACCESS	HbsAg Result: Date/ /			×		
Cannulation, Routine	HbsAb Result: Date / _ /					
Cannulation, Complex						
Needle size g	TREATMENT/LABS		Blood Products:			
Site Assessment (Note Area):	Heparin Free Protocol					
	Oxygen: Via:					
1111	Blood Sugar: mg/dl					
	Specimen Collection (circle):			t. *		
	H & H, CA, PO4,					
	PT, PTT BC x					
-	CBC, Chem Screen,		Folic Acid 1 mg p	00		
	Нер В		Surbex T, 1 po			
Access Flow Monitoring	(note panel or marker)					
Result:	Iron Profile, Ferritin					1
	PTH					
	Other:					
			,			
Hemostasismin/site						
			-			

FULL SIGNATURE	PRINT NAME	INIT	TITLE
	,		

Date: _

Dialysis Treatment CareMap®

	1	
Signature	Title	Initial
	*	

AFFIX PATIENT INFO LABEL HERI

Patient Name	MR#	
I GRIOTIF ITGITLE	STREET	

Treatment	Date:		
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PROBLEM / NEEDS	DESIRED OUTCOME	MET NOT MET*	PROBLEM / NEEDS	DESIRED OUTCOME	MET	NOT MET*
Access	Remains patent/functional throughout treatment			Albumin 3.5 Gm/dl		
	Hemostasis achieved 10min/site		Nutrition	Verbalizes understanding of diet & fluid restrictions		
Treatment Adequacy	URR > 70% (checked monthly)					
	Hgb 11.0 Gm		-	Active		
Anemia	T Sat 20-50% **Done Due Ferritin 100-800 ng/ml	64	Transplant Status (√ one only)	Work-up in progress	-	
	**Done Due	\\.	<u></u>			
	Achieved established dry weight		* .	Not a candidate (see LTCP)		
Fluid Management/ Hemodynamic Stability	Absence of edema, shortness of breath		Psychosocial	Exhibits successful adjustment to dialytic therapy through	-	
	Vital signs stable throughout treatment			compliance with therapeutic regimen		
	No Evidence of Infection	-		Patient/family verbalizes understanding of diagnosis and plan of care, and participates in decision making		
Infection	Hepatitis B Vaccine in progress or complete (✓ Kardex)		Knowledge Deficit Related to Plan of Care			
_	PTH assay 60 - 200 ng/dl (Checked quarterly) **Done Due					
Renal Osteodystrophy	P04 2.5 - 5.5 mg/dl		Pain Management	Denies pain		
	Ca/PO4 product 55		Management			
	K+ 3.5 - 6.0 mEq/L		Patient Safety	Remains injury free in a safe environment		
Electrolyte Imbalance	Na+ 130mEq/L					
	(Checked monthly)		Patient/Family Satisfaction	Patient/family verbalizes satisfaction with care		

^{*}Requires Progress Note

^{**}Requires Progress Note only with latest result, if not met



Date:	
Date.	

PATIENT PROGRESS RECORD CHRONIC HEMODIALYSIS UNIT

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Patient Name		MR#

		PHYSICIAN'S SHORT PROGRESS RECORD	
A. New Complaint	ts	Y	es 🗖 No
B. Recent Hospita	1.4.1		
C. Vascular Acces			
D. Vascular Acces			
		· Y	es 🖵 No
	Weight: kg		
New Physical Find	lings:		
Plan:			
		MD Signature:	
		NTERDISCIPLINARY PROGRESS RECORD	
Indicate date and	time of each entry.		
Print name under	signature following e	each entry.	
Date/Time	Discipline/		
	Department		
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