niagarahealth
Extraordinary Caring. Every Person. Every Time.

Hemodialysis Treatment/Downtime Record
Hemodialysis Program

Allergies ☐ NKA or _____

Date _____ (dd/mm/yyyy)

Site: ☐ SCS ☐ WHS ☐ NFS ☐ Centre ☐

Scheduled @ (hhmm): _____

Start @ (hhmm): _____

Stop @ (hhmm): _____

Admitted (hhmm) _____ ☐ InPt ☐ OutPt
☐ Ambulant ☐ WC ☐ Stretcher/Bed

Discharged (hhmm) _____ ☐ InPt ☐ OutPt
☐ Ambulant ☐ WC ☐ Stretcher/Bed

VITAL SIGNS

	Previous Post	Pre	Post
WT			
BP (L)			
BP (S)			
APEX Irregular			
Temp			
Res Rate			

CALCULATIONS

Pre Wt			kg
Ideal Wt	−		kg
Fld Wt	=		ml
Prime/Rinse	+		ml
Intake	+		ml
Output	−		ml
Parenteral flds	+		ml
Total	=		ml

DIALYSIS PRESCRIPTION

Ideal Weight _____ kg

Treatment Time (hours) _____

Dialyzer _____

Dialysate _____ potassium + bicarbonate/glucose
☐ low calcium ☐ high magnesium

Na _____ mmol/L ☐ Na profile ☐ UF profile

Na bandwidth _____ ☐ Hemo Control

Blood flow _____ ml/min

Dialysate flow _____ ml/min. Temp _____ °C

Anticoagulant Type Initial _____ units/hr
Continuous _____ units/hr

☐ Flush ☐ Tight ☐ Start _____ (ddmmyyyy) ☐ Stop _____ (ddmmyyyy)

Reason _____

Artery ☐ Metal ☐ Plastic ☐ lidocaine 2%

Vein ☐ Metal ☐ Plastic ☐ lidocaine 2%

PHYSICAL/ACCESS ASSESSMENT

	Pre	Post	Internal	R Pre	L Post	External	R Pre	L Post
	Please circle yes/no							
Disorientated	Yes/No	Yes/No	Bruit inaudible	☐	☐	Dsg Loose/wet	☐	☐
Edema	Yes/No	Yes/No	Redness	☐	☐	Exit site red/draining	☐	☐
Chest Pain	Yes/No	Yes/No	Hematoma	☐	☐	Clamps open/ Caps not secure	☐	☐
Dyspnea	Yes/No	Yes/No	Pain	☐	☐			
Breath Sounds	Clear / Other	Clear / Other	Other	☐	☐	Safety/restrain tape not secured	☐	☐

☐ Cannulation difficulties ☐ Flow Problem
☐ Sites held greater than 10 minutes
☐ Push bans ☐ Other: _____
Dialyzer streaking: ☐ Minimal ☐ Moderate ☐ Large

TREATMENTS / OTHERS

Access Flow: ☐ Done _____ mL/min

Recirculation _____ mL/min

CVAD Dressing Change q _____

Isolation: ☐ Yes ☐ No

Type: ☐ MRSA ☐ VRE ☐ Other _____

Medication changes since last visit: ☐ Yes ☐ No

ARI: ☐ Pass ☐ Fail Falls Risk: ☐ Yes ☐ No

Swabs Due: _____

PATIENT CARE ISSUES

MACHINE PRIMING CHECK

Station # _____ Machine ID # _____

☐ Prescribed dialyzer ☐ Prescribed dialysate

Disinfectant: ☐ Heat ☐ Chemical ☐ Free of residual

Priming procedure completed by _____
Signature

Acid concentrate added at _____ (hhmm)

By _____
Signature

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KIDN020

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Time	Timing (Comments)	Sit BPS	Sit BPD	Sit HR	UFR	UFV RM	BVP	BFR	DFR	Art P	Ven P	Anticoag Vol remain (mL)	BV % HCT	Ionic Kt/V	TMP	Initials

Hemocontrol Final BV / UF = _____

Date / Time dd/mm/yyyy hhmm	**Discipline**	**Focus**	**DARE**	**Notes**

Signature (Please Print & Sign)	**Initials**	**Signature** (Please Print & Sign)	**Initials**

KIDN020

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