

**ACUTE HEMODIALYSIS ASSESSMENT**

<p><b>HEMODIALYSIS ORDERS</b> Nephrologist: _____  Dialyzer: _____ Duration: _____ BFR: _____ DFR: _____ Goal: _____  Dialysate: K: _____ Ca: _____ Na: _____ Bicarb: _____  Sodium Modeling: _____ <input type="checkbox"/> NA UF Profiling: _____ <input type="checkbox"/> NA  Initial Heparin: _____ Units Bolus Units/Hr: _____ <input type="checkbox"/> No Heparin  Floor Chart Check <input type="checkbox"/> Consent Signed <input type="checkbox"/>  Additional Orders: _____</p>	<p><b>PATIENT INFORMATION</b>  Name: _____  Date: _____ Medical Record#: _____  Patient ID Verified <input type="checkbox"/> _____ Room#: _____  DX: _____  <input type="checkbox"/> 1st Time Acute <input type="checkbox"/> NA <input type="checkbox"/> Chronic Unit  <input type="checkbox"/> Allergies: _____ <input type="checkbox"/> NKA</p>
<p><b>CATHETER ACCESS</b> <input type="checkbox"/> Tunnel <input type="checkbox"/> Non Tunnel <input type="checkbox"/> NA  <input type="checkbox"/> Catheter <input type="checkbox"/> Patent <input type="checkbox"/> No S/S Infection <input type="checkbox"/> Clotted  <input type="checkbox"/> Redness <input type="checkbox"/> Drainage: _____ <input type="checkbox"/> Swelling <input type="checkbox"/> Pain  <input type="checkbox"/> Dry/Intact Last Dressing Change: _____  Location: _____ Access Flows: <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Positional</p>	<p>Code Status: _____  <b>MOBILITY</b>  <input type="checkbox"/> Bed <input type="checkbox"/> Stretcher <input type="checkbox"/> Wheel Chair <input type="checkbox"/> IV <input type="checkbox"/> O2  <input type="checkbox"/> Acute Room <input type="checkbox"/> Bedside <input type="checkbox"/> ICU/CCU <input type="checkbox"/> ER</p>
<p><b>GRAFT/FISTULA ACCESS</b> <input type="checkbox"/> NA <input type="checkbox"/> Buttonhole  <input type="checkbox"/> AVG <input type="checkbox"/> AVF <input type="checkbox"/> Patient <input type="checkbox"/> No S/S Infection <input type="checkbox"/> Clotted  Location: _____ Access Flows: <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Positional  <input type="checkbox"/> Redness <input type="checkbox"/> Drainage: _____ <input type="checkbox"/> Swelling <input type="checkbox"/> Pain  Bruit/Thrill: <input type="checkbox"/> Pre Needle Gauge: _____ Length: _____  Initials: _____</p>	<p><b>ISOLATION</b>  <input type="checkbox"/> NA <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> C-DIFF <input type="checkbox"/> TB <input type="checkbox"/> Hepatitis Type</p>
<p><b>GENERAL ASSESSMENTS</b>  Lungs: <input type="checkbox"/> Clear <input type="checkbox"/> Crackles <input type="checkbox"/> Rhonchi <input type="checkbox"/> Wheezing <input type="checkbox"/> Rales  <input type="checkbox"/> Diminished Location: _____  Rate: _____ <input type="checkbox"/> Easy <input type="checkbox"/> Labored <input type="checkbox"/> Nasal Cannula <input type="checkbox"/> Mask  Oxygen%: _____ Saturation: _____% <input type="checkbox"/> Intubated <input type="checkbox"/> Trached <input type="checkbox"/> Ventilator</p>	<p><b>DIET</b>  Type: _____ <input type="checkbox"/> Tube Feed _____ ml/hr <input type="checkbox"/> TPN _____ ml/hr</p>
<p><b>CARDIAC</b> <input type="checkbox"/> Monitor  Heart Rate: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Pericardial Rub <input type="checkbox"/> JVD</p>	<p><b>HEMODIALYSIS MACHINE SAFETY CHECKS - Before Each Treatment</b>  Machine#: _____ RO# _____ Auto/Alarm Test: <input type="checkbox"/> Passed <input type="checkbox"/> Failed  Chlorine Residual: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> RO Log Complete  Dialysis: pH _____ Temp: _____ <input type="checkbox"/> Extracorporeal Circuit Tested for Integrity  Meter#: _____ Conductivity: _____ Machine: _____</p>
<p><b>EDEMA</b> <input type="checkbox"/> NA  <input type="checkbox"/> Generalized <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Facial <input type="checkbox"/> Upper Ext.  <input type="checkbox"/> Lower Ext. <input type="checkbox"/> Pitting Edema+ _____ <input type="checkbox"/> Pedal</p>	<p><b>CURRENT LABS</b> <input type="checkbox"/> Drawn Pre  BUN: _____ Creatinine: _____ Na: _____ K: _____ Cl: _____ CO<sub>2</sub>: _____  Ca: _____ Phos: _____ Mg<sup>++</sup>: _____ Albumin: _____  Glucose: _____ Hgb: _____ Hct: _____ WBC: _____  Platelet: _____ PTT: _____ Hepatitis B Status: _____  Date: _____ Initials: _____</p>
<p><b>SKIN</b>  <input type="checkbox"/> Warm <input type="checkbox"/> Pink <input type="checkbox"/> Hot <input type="checkbox"/> Cool <input type="checkbox"/> Dry <input type="checkbox"/> Pale <input type="checkbox"/> Diaphoretic  <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced <input type="checkbox"/> Cyanotic <input type="checkbox"/> Weeping <input type="checkbox"/> Rash</p>	<p><b>EDUCATION</b>  <input type="checkbox"/> Patient <input type="checkbox"/> Other: _____  Knowledge Basis: <input type="checkbox"/> None <input type="checkbox"/> Minimal <input type="checkbox"/> Substantial  Inappropriate due to: _____  <input type="checkbox"/> Access Care <input type="checkbox"/> S&amp;S Infection <input type="checkbox"/> Fluid Management <input type="checkbox"/> Potassium  <input type="checkbox"/> Phosphorus <input type="checkbox"/> Medication <input type="checkbox"/> Tx Options <input type="checkbox"/> Tx Adequacy <input type="checkbox"/> Transplant  <input type="checkbox"/> Diet <input type="checkbox"/> Other: _____  Teaching Tools: <input type="checkbox"/> Explain <input type="checkbox"/> Demo <input type="checkbox"/> Handout <input type="checkbox"/> Video</p>
<p><b>L.O.C.</b>  <input type="checkbox"/> Alert <input type="checkbox"/> OrientedX: _____ <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time  <input type="checkbox"/> Confused <input type="checkbox"/> Lethargic <input type="checkbox"/> Sedated <input type="checkbox"/> Comatose</p>	<p><b>POST TREATMENT</b>  Dialyzer Clearance: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor  <input type="checkbox"/> Capping: Heparin: _____ Units/ml Arterial Vol.: _____ Venous Vol.: _____  <input type="checkbox"/> AVF/AVG Bleeding Stopped Arterial: _____ min. Venous: _____ min.  Initials: _____</p>
<p><b>PAIN</b>  <input type="checkbox"/> 0-None <input type="checkbox"/> 1-3-Mild <input type="checkbox"/> 4-6-Moderate <input type="checkbox"/> 7-10-Severe  Location/Action: _____</p>	<p><input type="checkbox"/> Respiratory: _____ <input type="checkbox"/> Skin: _____  <input type="checkbox"/> Cardiac: _____ <input type="checkbox"/> LOC: _____  <input type="checkbox"/> Edema: _____ <input type="checkbox"/> GI: _____</p>
<p><b>GI/ABDOMEN</b>  <input type="checkbox"/> Flat <input type="checkbox"/> Distended <input type="checkbox"/> Soft <input type="checkbox"/> Firm  <input type="checkbox"/> Diarrhea <input type="checkbox"/> Bowel Sounds <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting</p>	<p>Acute Nurse Signature / Title: _____ Date: _____</p>
<p>Pre-Treatment RN Signature: _____  Date: _____ Time: _____</p>	

(Optional) Physician Note: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



PT.

MR.#/P.M.

DR.