

## McLaren Print System Order

Order No: 46092 Reprint Previous Order No: 6396  
 Order Date: 2019-06-10  
 User: sam wolcott  
 Phone: 810 342 2575

Ship Location: McLaren Flint Acute Dialysis

### Forms

Quantity: 500  
 Paragon Dept No: 44010  
 Dept Name: dialysis  
 Company Number: 60

Order Total Price: 61.50

Item Number: 3674  
 Item Description: Acute Hemodialysis Assessment  
 Revision Date: 4/2018  
 Print: 1 sided black and white  
 Paper: 2 Part (White, Yellow)  
 Size: 8.5 x 11  
 Fold:  
 Finish:  
 Drill: 5 Hole Top 3 Hole Side  
 Misc Info:

MCLAREN FLINT  
 FLINT MICHIGAN 48903  
**ACUTE HEMODIALYSIS ASSESSMENT**

<b>HEMODIALYSIS ORDER</b> Reorder # _____ Request: R _____ Ca _____ No _____ Initial Request: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending <input type="checkbox"/> Cancel Prior Test Order: <input type="checkbox"/> Consent Signed <input type="checkbox"/> Refuse <input type="checkbox"/> Additional Orders: _____		<b>PATIENT INFORMATION</b> Name: _____ Patient ID/Bed # _____ SSN: _____ The Time Acute: <input type="checkbox"/> Chronic Unit <input type="checkbox"/> Challenge: _____ Check _____	
<b>EXAMINER ACCESS</b> <input type="checkbox"/> Nurse <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> PA <input type="checkbox"/> Physician <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Student <input type="checkbox"/> Dietician <input type="checkbox"/> Therapist <input type="checkbox"/> Social Worker <input type="checkbox"/> Other Last Training Date: _____ Location: _____		<b>SOBILITY</b> <input type="checkbox"/> Able <input type="checkbox"/> Transfer <input type="checkbox"/> Chair <input type="checkbox"/> Gait <input type="checkbox"/> Cane/Walker <input type="checkbox"/> Bedside _____	
<b>QUARTERMASTER ACCESS</b> <input type="checkbox"/> Nurse <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> PA <input type="checkbox"/> Dietician <input type="checkbox"/> Therapist <input type="checkbox"/> Social Worker <input type="checkbox"/> Other Location: _____ Access Point: <input type="checkbox"/> Quads <input type="checkbox"/> Feet <input type="checkbox"/> Proximal <input type="checkbox"/> Reversible <input type="checkbox"/> Irreversible <input type="checkbox"/> Heating <input type="checkbox"/> Pain Seal/Flap: <input type="checkbox"/> Other _____ Length: _____ Initial: _____		<b>ADL/AVD</b> <input type="checkbox"/> Bath <input type="checkbox"/> Groom <input type="checkbox"/> Dress <input type="checkbox"/> Eat <input type="checkbox"/> Transfer <input type="checkbox"/> Walk <input type="checkbox"/> Stair <input type="checkbox"/> Drive <input type="checkbox"/> Other _____	
<b>GENERAL ASSESSMENTS</b> Large: <input type="checkbox"/> None <input type="checkbox"/> Small <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Risk <input type="checkbox"/> Decreased <input type="checkbox"/> Location: _____ Pain: _____ Euphoric: <input type="checkbox"/> Sedated <input type="checkbox"/> Anxious <input type="checkbox"/> Agitated <input type="checkbox"/> Irritable		<b>HEMODIALYSIS MACHINE SAFETY CHECKS: Before Each Treatment</b> Machine: _____ Autoclave Test: <input type="checkbox"/> Passed <input type="checkbox"/> Failed Electrical Test: <input type="checkbox"/> Passed <input type="checkbox"/> Failed <input type="checkbox"/> Pending Safety pin: _____ Emergency Circuit Tested for Integrity: _____ Status: _____	
<b>CARDIAC</b> Heart Rate: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Normal <input type="checkbox"/> Abn ECG: _____		<b>CURRENT LABS</b> (Date: _____) (Screening: _____) BUN: _____ Creatinine: _____ Ca: _____ Phos: _____ Mg: _____ Glucose: _____ High: _____ Hct: _____ WBC: _____ Hemat: _____ PTT: _____ Initial: _____ Hepatitis B Antibodies: _____ Date: _____ Hepatitis B Antigen: _____ Date: _____ Initial: _____	
<b>EDUCATION</b> <input type="checkbox"/> Patient <input type="checkbox"/> Other Knowledge Base: <input type="checkbox"/> None <input type="checkbox"/> Minimal <input type="checkbox"/> Substantial Incompetent due to: <input type="checkbox"/> Patient Care <input type="checkbox"/> Infection <input type="checkbox"/> Fluid Management <input type="checkbox"/> Prescription <input type="checkbox"/> Hemodynamic <input type="checkbox"/> Medication <input type="checkbox"/> Vitals <input type="checkbox"/> Access <input type="checkbox"/> Transport Other: <input type="checkbox"/> Other Teaching Tools: <input type="checkbox"/> Explain <input type="checkbox"/> Demonstrate <input type="checkbox"/> Other		<b>POST TREATMENT</b> Patient Discharge: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Clamping: <input type="checkbox"/> Healed <input type="checkbox"/> Intact <input type="checkbox"/> Anesth <input type="checkbox"/> Sensor Wk <input type="checkbox"/> Dialysis: <input type="checkbox"/> Done <input type="checkbox"/> No <input type="checkbox"/> Cuff/ABP: <input type="checkbox"/> Stopped <input type="checkbox"/> Manual <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No Initial: _____	
<b>DATE/FILL</b> R/S: _____ Location: _____		<b>DATE/FILL</b> R/S: _____ Location: _____ Competency: _____ Checked: _____ Signed: _____ Date: _____ Time: _____ Initial: _____	
<b>SHARDOWN</b> <input type="checkbox"/> Other <input type="checkbox"/> Standard <input type="checkbox"/> Clean <input type="checkbox"/> Other <input type="checkbox"/> PO <input type="checkbox"/> Other <input type="checkbox"/> Other <input type="checkbox"/> Other <input type="checkbox"/> Other <input type="checkbox"/> Other		_____ _____ _____	

ACUTE HEMODIALYSIS ASSESSMENT  
 7500