Winnipeg Regional Health Authority — Caring for Health
Office régional de la santé de Winnipeg — À l'écoute de notre santé
kidneyhealth.ca — manitoba renal program

RENAL PATIENT KARDEX

PART 1

Patient Information

Advance Care Plan Status: Date (DD MMM YYYY) ________
☐ Comfort ☐ Medical ☐ Resuscitation

Allergies ____________________

Isolation ☐ Yes ☐ No Indications ____________________

Isolation Swabs: .... Date (DD MMM YYYY) ________

Results: MRSA: ________ VRE: ________

Other: ____________________

Next Clinic Visit Appointment: Time (24 HOUR) ________ Date (DD MMM YYYY) ________

☐ Caucasian ☐ Asian specify: ____________________

☐ Inuit ☐ Black ☐ Metis ☐ First Nation ☐ Treaty

Treaty # ________ Band ________

☐ Interpreter Required ☐ Escort Required

EIA# ________ Worker Name ________

Phone ___-___-___

Chronic Kidney Disease (CKD) History

	Site	Date (DD MMM YYYY)
Renal Clinic		
Hemodialysis		
Peritoneal Dialysis		

Medical/Surgical History

____

	Date (DD MMM YYYY)
Chest X-ray	
EKG	

Erythropoietic Therapy ☐ Yes ☐ No

Date Started (DD MMM YYYY) ________

Person Administering ____________________

Home Care Nurse ____________________

Phone ___-___-___ Fax ___-___-___

Warfarin ☐ Yes ☐ No **Clopidogrel** ☐ Yes ☐ No

Target INR Range ________ Indication ________

Followed by ____________________

Contact Information

Date (DD MMM YYYY) Updated ________

Address ____________________

Phone ___-___-___ Cell ___-___-___

Alternate Phone ___-___-___

Temporary Address ____________________

Temporary Phone ___-___-___

Contact Person ____________________

Phone ___-___-___ Cell ___-___-___

Family Physician ____________________

Phone ___-___-___ Fax ___-___-___

Health Facility ____________________

Phone ___-___-___ Fax ___-___-___

Nursing Station ____________________

Phone ___-___-___ Fax ___-___-___

Lab ____________________

Phone ___-___-___ Fax ___-___-___

Pharmacy ____________________

Phone ___-___-___ Fax ___-___-___

Transportation Mode ____________________

Phone ___-___-___ Account # ________

Home Care ☐ Yes ☐ No

Coordinator/Nurse ____________________

Phone ___-___-___ Fax ___-___-___

Allied Health

	Phone
Social Worker	___-___-___
Dietitian	___-___-___
Pharmacist	___-___-___
Aboriginal Services	___-___-___
Occupational Therapist	___-___-___
Other	___-___-___

Vaccinations

	Result	Date (DD MMM YYYY)
Hepatitis B Antigen		
Hepatitis B Antibody		

Hepatitis Immunization

1st Series Completed ☐ Yes ☐ No ________

2nd Series Completed ☐ Yes ☐ No ☐ N/A ________

Booster ________ Non-responder

Pneumovax: Date Given (DD MMM YYYY) 1st Dose ________ Date Given (DD MMM YYYY) 2nd Dose ________

Mantoux:

	Result	Date (DD MMM YYYY)
Step 1	________ mm	
Step 2	________ mm	

Influenza Vaccination ____________________

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PART 1

Renal Education Summary

	Date (D D M M M Y Y Y Y)		Date (D D M M M Y Y Y Y)
☐ 1 to 1 Renal Education		☐ Renal Education Class	
Education Material Provided			
☐ Manitoba Renal Program Patient Education Manual		☐ Renal Health Clinic "Starter Kit"	
☐ Kidney Foundation Manual			

Other Information ______

(Refer to Renal Education Sheet for details)

Modality Assessment and Planning*

	Date of Consult (D D M M M Y Y Y Y)	Site	Accepted YES	Accepted NO	Accepted PENDING
☐ Peritoneal Dialysis			☐	☐	☐
☐ Home Hemodialysis			☐	☐	☐
☐ In-centre Hemodialysis			☐	☐	☐
Closest Local Renal Health Centre			☐ *Tracking List Referral Sent*		
☐ Transplant			☐	☐	☐
Potential Living Donor ☐ *yes* ☐ *No* ☐ *Unknown*					
☐ End of Life Care Choice					

Vascular Access Planning

	Date (D D M M M Y Y Y Y)	
Consult Sent		Plan ☐ CVC ☐ AVF ☐ AVG Location ______
Vascular Access Created		Surgeon ______

Appointments/Consults

Appointment/Consult	Dates: Requisition Faxed (D D M M M Y Y Y Y)	Dates: Appointment (D D M M M Y Y Y Y)	Dates: Report Received (D D M M M Y Y Y Y)	Attendance Yes/No	Notes

05/17