

Manitoba Renal Program & Long Term Care Communication Record

PART 1: To be completed by Long Term Care Unit

Unit/Facility _____

Changes Since Last Dialysis Treatment

Visit Date:

D	D	M	M	M	Y	Y	Y	Y											

- NO YES** *If yes, provide details below*
- Change in vascular access
- New Physician Orders
- Transferred to Acute Care facility

- NO YES** *If yes, provide details below*
- Level of consciousness, vital signs, prolonged bleeding
- Lab work or x-rays/imaging done with new findings

Other (specify) _____

Record of Documentation Included

Note: If there are significant changes in the patient's status, fax relevant portions of the health record to supplement what is documented on the completed Communication Record

- NO YES** *If yes, provide details below*
- Copy of current Advance Care Planning - Goals of Care **(form to accompany patient during transfer)**
- Medication Administration Record/Pyxis Medication List (include for each medication change)
- Other (specify) _____

NURSE'S SIGNATURE _____ PRINT NAME _____ DATE COMPLETED

D	D	M	M	M	Y	Y	Y	Y											

PART 2: To be completed by Dialysis Unit

Unit/Facility _____

Hemodialysis Treatment

# of Hours	
Heparin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vascular Access	<input type="checkbox"/> CVC <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> AVF/AVG <input type="checkbox"/> R <input type="checkbox"/> L
Dry Weight	_____ kg
Pre HD Weight	_____ kg
Post HD Weight	_____ kg

	Pre HD	Post HD
BP		
HR		
T°		
RR		
BG		

BLOOD WORK:

- CBC Chemistry INR
- Blood Cultures
- Other _____

BLOOD PRODUCTS given in HD:

MEDICATIONS/ANTIBIOTICS given in HD: _____

PATIENT ISSUES: _____

- NO YES** *If yes, provide details below*
- Nephrologist consulted due to new issues. Nephrologist's Name _____
- New Physician Orders _____

Documentation Faxed

Note: If there are significant changes in the patient's status, fax relevant portions of the health record to supplement what is documented on the completed Communication Record

- Physician's Orders MAR Other (specify) _____

NURSE'S SIGNATURE _____ PRINT NAME _____ DATE COMPLETED

D	D	M	M	M	Y	Y	Y	Y											

To be stored as per facility practice for a minimum of one month

KEY:	AVF - Arteriovenous Fistula	CVC - Central Venous Catheter	MAR - Medication Administration Record
	AVG - Arteriovenous Graft	HD - Hemodialysis	RR - Respiratory Rate
	BG - Blood Glucose	HR - Heart Rate	R - Right
	BP - Blood Pressure	L - Left	T° - Temperature