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

## 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 |
| ☐ | ☐ | 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** | ☐ Yes ☐ No |
| **Vascular Access** | ☐ CVC ☐ R ☐ L<br>☐ AVF/AVG ☐ R ☐ 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 |