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

Deer Lodge Centre — Making lives better

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