

Caregiver Dialysis Patient Communication Form

To Be Completed by Caregiver

Patient Name: _____ Date: _____

Falls since last treatment: Yes No

If yes, please explain: _____

Access Issues (i.e. bleeding, drainage or pain): Yes No

Did the dressing/bandage come off the catheter? Yes No

To Be Completed by Dialysis Facility

Pre-Dialysis Treatment

Blood Pressure: _____ Temperature: _____ Pulse: _____ Weight: _____

Dialysis Treatment Orders

Target Weight: _____ Treatment Duration: _____

Medications Administrated During Dialysis Treatment

Post-Dialysis Treatment

Blood Pressure: _____ Temperature: _____ Pulse: _____ Weight: _____

Amount of Fluid Removed: _____

Did patient complete prescribed treatment: Yes No

If no, why? (cramping, low BP, other symptoms) _____

Please note any dialysis access problems (excess bleeding, infiltration, etc):

***To help reduce the risk of infection, remove the bandage once the bleeding stops.**

Nurse completing this form: _____