

Nursing Home Dialysis Patient Communication Form

To Be Completed by Nursing Home

Patient Name: _____ Date: _____

New medication orders (antibiotics, dose adjustments):

Vaccinations given since last dialysis treatment:

Pneumococcal	COVID-19	Influenza
RSV	Other	

Has patient been to hospital since last dialysis treatment?

Yes No

If yes, list hospital, admit/discharge dates, and diagnosis.

Admit Date: _____ Discharge Date: _____

Diagnosis: _____

New Infections? Yes No

List Diagnosis and Location: _____

Blood Cultures Drawn? Yes No

Date Drawn: _____

Isolation Precautions: Yes No

If yes, list precautions: _____

Upcoming medical appointments: _____

Upcoming Plan of Care (date): _____

Nurse completing this form:

Name: _____

Phone: _____

Please fax any hospital, vaccination, and lab results, including blood cultures to the dialysis facility.

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):

Nurse completing this form:

Name: _____

Phone: _____

Please attach a copy of any current labs that were drawn.