RE-ASSESSMENT SHEET

CENTRE NAME: .....
DATE: .....

Patient Name: ..... Age/sex: ..... UHID: .....

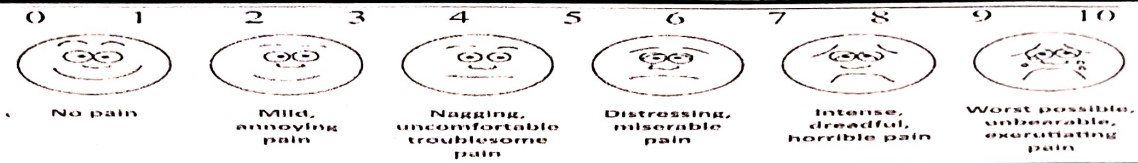
Bed/ Machine: ..... DMO/RMO: ..... Nephrologist .....

PHYSICIAN:-

CHEST	P/A EXAMINATION	CVS	CNS	VULNERABLE	PEDAL OEDEMA
.....	.....	.....	.....	Yes ☐ No ☐	Yes ☐ No ☐

DRY WEIGHT	UF GOAL	KNOWN ALLERGY	BLOOD TRANSFUSION	Hepar. FREE	K+ FREE	Ca++ FREE	Dext. FREE
.....	.....	.....	.....	☐	☐	☐	☐

PAIN ASSESSMENT (VISUAL ANALOGUE SCALE) ➡



DMO/RMO Notes (Medicine in Capital Letters)	Dialysis Nurse/ Technician Notes
Name & Sign: Time:	Name & Sign: Time:

DIALYSIS TECHNICIAN/NURSE:-

Weight (Last sess.):		Dialyzer Type:		Access Type:	
Weight (Pre):		Dialyzer Use:		Access Site Infection:	
Weight (Gain):		FBV:		Total Duration:	
Weight (Post):		Kt/ V:		Heparin Given (Total):	

Duration	TIME	BP	Pulse	Temp	SPO2	RR	BFR	DFR	STAFF NAME	SIGN
Pre										
00:30										
01:00										
01:30										
02:00										
02:30										
03:00										
03:30										
Post										

S.No.	Time	MEDICATION (Capital Letter)	Dose	Route	Frequency	Nurse Name	Sign

Discharge Notes: .....

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