



## DIALYSIS TREATMENT ORDER FORM (DOWNTIME)

| Ordering Doctor : <input type="text"/>   |   | Nephrologist : <input type="text"/>   |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
|--|---|---|--|------------------|------------------------|----------------------|---------------|------|----------------------|----------------|------|----------------------|------------|-----|----------------------|----------|----|----------------------|-----------------|---------|----------------------|---------|------|----------------------|---------------------|-----|----------------------|-------------------------|------|----------------------|-----------------|------|----------------------|-----------------|---|----------------------|-------------|--|----------------------|---------|--|----------------------|
| *Serology: <input type="text"/>  |   | Dialysis Treatment Date : <input type="text"/> Time : <input type="text"/>  |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| <input type="checkbox"/> HAEMODIALYSIS REGIME  |   | <input type="checkbox"/> CONTINUOUS RENAL REPLACEMENT THERAPY (CRRT) REGIME   |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Type : <input type="text"/>  | Dialysis Temperature : <input type="text"/> °C          | Type : <input type="text"/>   | Blood Flow Rate : <input type="text"/> mls/min   |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Heparin:<br>Loading : <input type="text"/> units<br>Hourly : <input type="text"/> units  | Blood Flow Rate (ml/min) : <input type="text"/> mls/min | Heparin :<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | Dialysate Flow Rate : <input type="text"/> mls/min   |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Duration :<br>Hours  | Dialysate Flow Rate : <input type="text"/> mls/min      |   | Replacement Fluid :<br>Pre <input type="text"/> mls/hr<br>Post <input type="text"/> mls/hr |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Special Order :<br><input type="text"/>  | Ultrafiltration : <input type="text"/> Litres           | Special Order :<br><input type="text"/>   | Fluid Removal : <input type="text"/> 0 mls/hr  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Date : <input type="text"/> Time Comment: <input type="text"/>   |   |   |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| *Machine ID & Asset Number <input type="text"/>  |   | *Machine ID & Asset Number <input type="text"/>   |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Dialysis Location : <input type="text"/>   |   |   |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| PRE-DIALYSIS ASSESSMENT (For Haemodialysis Treatment only)   |   |   |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Dry Weight (kg) : <input type="text"/>   |   | Access: <input type="text"/>  | Type : <input type="text"/>  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Pre Weight (kg) : <input type="text"/>   |   |   |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Dyspnoea: <input type="text"/>   |   |   |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Oedema : <input type="text"/>  |   |   |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Pre HD Vital Signs   |   | OBSERVATION (INTRADIALYTIC-For Haemodialysis Treatment Only)  |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Blood Pressure: Systolic <input type="text"/> mmHg<br>Diastolic <input type="text"/> mmHg<br>Pulse : <input type="text"/> /min<br>Temperature : <input type="text"/> °C<br>Pain Score : <input type="text"/> / <input type="text"/>  |   | <table border="1"><thead><tr><th>Observation Item</th><th>Normal Reference Range</th><th><input type="text"/></th></tr></thead><tbody><tr><td>BP - Systolic</td><td>mmHg</td><td><input type="text"/></td></tr><tr><td>BP - Diastolic</td><td>mmHg</td><td><input type="text"/></td></tr><tr><td>Heart Rate</td><td>bpm</td><td><input type="text"/></td></tr><tr><td>Pt Temp.</td><td>°C</td><td><input type="text"/></td></tr><tr><td>Blood Flow Rate</td><td>mls/min</td><td><input type="text"/></td></tr><tr><td>Heparin</td><td>Unit</td><td><input type="text"/></td></tr><tr><td>Total Fluid Removed</td><td>mls</td><td><input type="text"/></td></tr><tr><td>Trans Membrane Pressure</td><td>mmHg</td><td><input type="text"/></td></tr><tr><td>Venous Pressure</td><td>mmHg</td><td><input type="text"/></td></tr><tr><td>Ultrafiltration</td><td>L</td><td><input type="text"/></td></tr><tr><td>Pains Score</td><td></td><td><input type="text"/></td></tr><tr><td>Remarks</td><td></td><td><input type="text"/></td></tr></tbody></table> |  | Observation Item | Normal Reference Range | <input type="text"/> | BP - Systolic | mmHg | <input type="text"/> | BP - Diastolic | mmHg | <input type="text"/> | Heart Rate | bpm | <input type="text"/> | Pt Temp. | °C | <input type="text"/> | Blood Flow Rate | mls/min | <input type="text"/> | Heparin | Unit | <input type="text"/> | Total Fluid Removed | mls | <input type="text"/> | Trans Membrane Pressure | mmHg | <input type="text"/> | Venous Pressure | mmHg | <input type="text"/> | Ultrafiltration | L | <input type="text"/> | Pains Score |  | <input type="text"/> | Remarks |  | <input type="text"/> |
| Observation Item   | Normal Reference Range                                  | <input type="text"/>  |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| BP - Systolic  | mmHg  | <input type="text"/>  |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| BP - Diastolic   | mmHg  | <input type="text"/>  |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Heart Rate   | bpm   | <input type="text"/>  |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Pt Temp.   | °C  | <input type="text"/>  |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Blood Flow Rate  | mls/min   | <input type="text"/>  |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Heparin  | Unit  | <input type="text"/>  |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Total Fluid Removed  | mls   | <input type="text"/>  |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Trans Membrane Pressure  | mmHg  | <input type="text"/>  |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Venous Pressure  | mmHg  | <input type="text"/>  |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Ultrafiltration  | L   | <input type="text"/>  |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Pains Score  |   | <input type="text"/>  |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Remarks  |   | <input type="text"/>  |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| MRObservations.ListEMR 0.016484 (secs), 17595 (lines), 917 (globals)   |   |   |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| POST HAEMODIALYSIS ASSESSMENT  |   |   |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| General Condition:   |   | Vital Signs:  |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| <input type="checkbox"/> Comfortable <input type="checkbox"/> Weak<br><input type="checkbox"/> Giddiness <input type="checkbox"/> SOB<br><input type="checkbox"/> Chills/Rigors <input type="checkbox"/> Cramps<br><input type="checkbox"/> Chest Pain<br>Fistula Thrill<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | B/P Systolic: <input type="text"/> mmHg<br>B/P Diastolic : <input type="text"/> mmHg<br>Heart Rate: <input type="text"/> /min<br>Temperature: <input type="text"/> °C<br>Pain Score : <input type="text"/> / <input type="text"/>   |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Blood Volume processed : <input type="text"/> Litres   |   | Status<br>Terminated/Completed By : <input type="text"/><br>Completed Time : <input type="text"/>   |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Post Weight : <input type="text"/> kg  |   |   |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |
| Remarks : <input type="text"/>   |   |   |  |                  |                        |                      |               |      |                      |                |      |                      |            |     |                      |          |    |                      |                 |         |                      |         |      |                      |                     |     |                      |                         |      |                      |                 |      |                      |                 |   |                      |             |  |                      |         |  |                      |

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date & Time: \_\_\_\_\_