Dialysis care plan

NAME ID NUMBER DIALYSIS CENTRE

Date: Date Of Starting HD at 7Med :

Drug Allergy:

Date						
Dry Weight						
Dialysis Time (mins)						
Blood Flow Rate (Qb)						
Needle Size A / V						
Maximum UF Rate / hour						
Dialyser						
Dialysate Type						
Dialysate Temp.						
Dialysate Flow						
Heparin Loading / Hourly						
Washback Volume						
Staff Name /Signature						
Dialysis Schedule Fequency per week						
Access Flow Monitoring Frequency						
Prescribing Doctor's sign						

HEPATITIS B VACCINATION

	1st	2nd	3rd	Booster
Date				

DOCTOR	APPOINTMNET DATE	SPECIAL INSTRUCTION IF ANY		SIGNATURE
		DATE		
		DATE		
		DATE		
		DATE		
		DATE		
		DATE		
		DATE		
		DATE		
		DATE		