

Facility Name
Comprehensive Review / Patient Care Planning Conference

Patient Name: MASTER COPY
Med Rec # 0000

Conference Date:
 Due NP X _____ Hosp

Physician:

Dialysis Rx: ___ x wk ___ hrs Dialyzer _____ Current Dry Wt. _____
Bath: _____ K+ _____ Ca++ _____ HCO3 _____ Na+ Mod _____ UFP _____
Access: _____ Surg / RI: _____ Access History/Kardex current
Access Problems: None Decr Kt/V Ext. Bleed Infection Other _____

NURSING

- | | | | | |
|--|-----------------------------------|------------------------------------|---|---|
| <input type="checkbox"/> No concerns | <input type="checkbox"/> Adequacy | Kt/V _____ | URR _____ | K+ _____ / _____ |
| <input type="checkbox"/> Weight gains/Dry weight | <input type="checkbox"/> Anemia | Hct _____ / _____ | Hgb _____ / _____ | |
| <input type="checkbox"/> Hyper/ Hypotension | <input type="checkbox"/> Aranesp | <input type="checkbox"/> EPO _____ | (prev adj date (↓,↑) _____) | |
| <input type="checkbox"/> Complaints of Pain | | TSat _____ | Ferritin _____ | Retic Ct. _____ |
| | | Venofer _____ | Carnitor _____ | (A or H) |
| <input type="checkbox"/> Compliance Issues | <input type="checkbox"/> Bone | Ca++ _____ / _____ | Phos _____ / _____ | PTH _____ |
| | <input type="checkbox"/> Calcijex | <input type="checkbox"/> Zemplar | <input type="checkbox"/> Hectoral _____ | mcg <input type="checkbox"/> Sensipar _____ |
| <input type="checkbox"/> Infectious Disease | SGOT _____ | SGPT _____ | HbSab _____ | Other _____ |

Assessment/Plan: _____

RN _____ Date _____

NUTRITION

- | | | | | |
|---|---|----------------------|-------------|----------|
| <input type="checkbox"/> Lab Review | Albumin _____ | Corrected Ca++ _____ | Chol _____ | Tg _____ |
| <input type="checkbox"/> Nutritional Intake / Compliance Issues | <input type="checkbox"/> Nutritional Supplement | _____ | | |
| <input type="checkbox"/> Diabetic: Current Insulin | _____ | Glucose _____ | HbA1c _____ | |
| <input type="checkbox"/> Med Review: Vitamins | _____ | Binders _____ | Vit D _____ | |

Assessment/Plan: _____

RD _____ Date _____

SOCIAL SERVICE

- | | |
|--|--|
| <input type="checkbox"/> No concerns | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Psychosocial Issues | <input type="checkbox"/> Insurance problems / Financial issues |
| <input type="checkbox"/> Adjustment to dialysis/modality | <input type="checkbox"/> Rehab needs: Vocational / Physical |
| <input type="checkbox"/> Life Plan current / complete | <input type="checkbox"/> Functional status |
| Transplantation: <input type="checkbox"/> Active <input type="checkbox"/> Pending <input type="checkbox"/> N/A Transplant Center _____ | |

Assessment/Plan: _____

SW _____ Date _____

PATIENT CONCERNS

| | | |
|---------------------------|---|---|
| MEDICAL ASSESSMENT | <input type="checkbox"/> Patient Stable | <input type="checkbox"/> Patient Unstable |
| CRF | | Cardiovascular |
| Diabetes | | Anemia |
| Bone Disease | | Access |
| Nutrition | | Transplant |
| Infection | | Other |

Physician Signature _____ Date _____ Patient Signature _____

Facility Name

Comprehensive Review / Patient Care Planning Conference

| Goals / Active Problem List | Action Plan | 15 day Re-eval |
|-----------------------------|-------------|----------------|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

Patient Education / Review of Problem List

| Problem Reviewed | Patient Education / Goals | Staff Signature |
|------------------|---------------------------|-----------------|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

Patient Signature

Date Reviewed