McLAREN FLINT FLINT, MICHIGAN 48532

ACUTE HEMODIALYSIS TREATMENT FLOW RECORD

Time On		Р	Pre B/P		AP/HR		Temperature		Resp. Rate		Pr	Pre Weight		Dry Weight	Machine #		
Time Off		Po	Post B/P		AP/HR		Temperature		Resp. Rate		Po	Post Weight		st Weight Off	Station #		
Primary	y Nurse	Report a	nd Treatm	nent Initia	ation Note	e:											
Acute N	Nurse Sig	gnature /	Title:								Initia	als:	Dat	e:			
Time	BP	Pulse BFR AP DFR V		AP VP	Temp. Conductiv		y TMP UFR		Fluid Remov	d Heparir val Infused	NS Flush ml	Safety Check*	Suction Check**	tion k** Notes and Comments		Initials	
Crit-Line UF Goa			r □ No, If						_		П	1					
UF GOA	ı wetr	Li tes oi	□ INO, II I	по ехріаі	<u> </u>		IOIAL	<u> </u>				Iotai	Blood Pr	ocessed:			
Note:																	
Acute Nurse Signature / Title:									RATE 0-	PAIN 10	Initio	Initials: Date:					
Time	vuise Si	_	tion/Blood	<u> </u>	Dose Volume			Route	Pre	1° Post	Reason		Dai	Nurse Signature			
					1220	10.					<u> </u>					\dashv	
	_			1													
Pre-Tx Report to Hospital RN: ☐ Yes Name:												Time: Time:					
MD Signature (optional): Date:										Time	Time:						
* Safety Checks are the following: Access and Face visiable at all times,										DT							

** Suction check.

MR.#/P.M.

TREATMENT FLOW RECORD 3651-A 3/17

ACUTE HEMODIALYSIS