CAMP DORSET HEMODIALYSIS PRESCRIPTION

*****REQUIRED 3 WEEKS IN ADVANCE OF PATIENT ARRIVAL*****

Name:		**Date of Birth:**	
Health Card:			
Allergies:		**Code Status:**	❑Full Code ❑ NO CPR (send supporting documents)

Frequency:		**Tx Time (4 hr max):**	

DIALYSIS PRESCRIPTION			**Access Type**	
Dialyzer:	❑ Revaclear 300 ❑ Other_____		❑ AVF ❑ GRAFT ❑ CVC ❑ L ❑ R	
Dialysate: *No additives*	❑ K1 ❑ K2 ❑ K3 ❑ CA 1.25 (only) BICARB: ❑ 35mmol/L ❑ 38 mmol/L		Button Hole: ❑ Yes ❑ No	
			Need Type: ❑ Sharp ❑ Dull	
Dialysate flow: 500ml (standard)		Dialysate Temp:	Gauge: ❑ 15g ❑ 16g	Length: ❑ ¾" ❑ 1"
Dialysate Na+: _____ mmol/L		Pump Speed:	❑ Self Cannulation	
Max fluid removed/hr:		Dry Weight:	**Post CVC Capping Protocol:** ❑ Lock CVC with Sodium Citrate 4% 2.5ml at both lumens ❑ Lock CVC with Heparin 1000 units and use _____ mls of NaCl 0.9% to fill ❑ Alteplase _____mg to reach CVC port and use_____mls of NaCl to fill	
❑ Heparin 1000u/ml: Bolus _____ Hourly _____ Stop:_____				
❑ Dalteparin Injection: _____ units at start of HD ❑ Other: _____ units ❑ NS 0.9% flushes				

MEDICATION DURING DIALYSIS: ❑ **EPREX** ❑ **ARANESP** ❑ **Other**_____		**HEPATITIS B STATUS** (Must be taken 60 days of camp arrival)	
Dose:	Freq:	Date Taken:	
Other:		HbsAg:	HbsAb:
MEDICAL HISTORY/ CURRENT ISSUES:		**USUAL BLOOD PRESSURE**	
		Pre:	During:
		Post:	
		BP/UF shut off point:	

Send 3 most recent treatment records with the Prescription

MANDATORY TO PROVIDE UPON CHECK-IN

1) **Nurse/Patient is responsible to bring alternative circuit anti-coagulation for all treatments**
2) **Nurse/Patient is responsible to bring dialyzer and acid concentrate if different from Camp standard**
3) **Nurse/Patient is responsible to bring Cathflo® (Alteplase) – for capping of CVC lines only**
4) **Last 3 Treatment Records and any new changes to Dialysis Prescription**

Complete this document and sign by Nephrologist or Nurse Practitioner (NP)

_____ _____

Nephrologist/NP signature Date