**UMC Health System**

# HEMODIALYSIS EXCHANGE PLAN

**Patient Label Here**

**PHYSICIAN ORDERS**

**Diagnosis** _____

**Weight** _____ **Allergies** _____

**Place an "X" in the Orders column to designate orders of choice AND an "x" in the specific order detail box(es) where applicable.**

| ORDER | ORDER DETAILS |
|---|---|
| | **Patient Care** |
| | **Hemodialysis Treatment Date** |
| | **Hemodialysis Type**<br>☐ Hemodialysis Type: Maintenance<br>☐ Hemodialysis Type: Induction<br>☐ Hemodialysis Type: Acute |
| | **Hemodialysis Procedure**<br>☐ Hemodialysis Procedure: Hemodialysis<br>☐ Hemodialysis Procedure: Isolated Ultrafiltration |
| | **Hemodialysis Duration**<br>☐ T;N |
| | **Hemodialysis Dialyzer**<br>☐ T;N, Hemodialysis Dialyzer: F160NR<br>☐ T;N, Hemodialysis Dialyzer: Other |
| | **Hemodialysis Dialysate**<br>☐ Hemodialysis Dialysate: 3K<br>☐ Hemodialysis Dialysate: 2K<br>☐ Hemodialysis Dialysate: 1K<br>☐ Hemodialysis Dialysate: 4K |
| | **Hemodialysis Dialysate Calcium**<br>☐ Dialysate Calcium: Standard Calcium 2.5<br>☐ Dialysate Calcium: Low Calcium 2.25 (Only with 2K)<br>☐ Dialysate Calcium: Bicarbonate Concentration<br>☐ Dialysate Calcium: Sodium Variation |
| | **Hemodialysis Dialysate Flow Rate**<br>☐ T;N, Flow Rate (mL/min) 1.5xBFR |
| | **Hemodialysis Blood Flow Rate**<br>☐ Blood Flow Rate: 300 HD Catheter<br>☐ Blood Flow Rate: 400 AVF/AVG<br>☐ Blood Flow Rate: Other: Complete Special Instructions<br>☐ Blood Flow Rate: 350 HD Catheter<br>☐ Blood Flow Rate: 450 AVF/AVG |
| | **Hemodialysis Ultrafiltration Goal**<br>☐ Ultrafiltration Goal: To Estimated Dry Weight<br>☐ Ultrafiltration Goal: 2 Liters<br>☐ Ultrafiltration Goal: 4 Liters<br>☐ Ultrafiltration Goal: 1 Liter<br>☐ Ultrafiltration Goal: 3 Liters<br>☐ Ultrafiltration Goal: Other |
| | **AVF/AVG Needle Gauge**<br>☐ Needle Gauge: 14 Gauge<br>☐ Needle Gauge: 16 Gauge<br>☐ Needle Gauge: 15 Gauge<br>☐ Needle Gauge: 17 Gauge |
| | **Communication** |
| | **Notify Nurse (DO NOT USE FOR MEDS)**<br>☐ T;N, Keep Mean Arterial Pressure above ____. |
| | **Notify Provider of VS Parameters (Notify Provider if VS)**<br>☐ SBP Greater Than 200, SBP Less Than 90, HR Greater Than 110, HR Less Than 50, Notify Nephrologist |
| | **Notify Nurse (DO NOT USE FOR MEDS)**<br>☐ T;N, UF ___ mL with crit-line guidance. If systolic BP greater than ____ and "B" profile continue fluid removal not to exceed ____ mL. Do "refill check" last 10 min. of treatment to evaluate plasma refill. |
| | |

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

**Physician Signature**: _____ **Date** _____ **Time** _____

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**Patient Label Here**

**PHYSICIAN ORDERS**

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| ORDER | ORDER DETAILS |
|---|---|
| | **Notify Nurse (DO NOT USE FOR MEDS)**<br>☐ T;N, UF ___ mL with crit line guidance to maintain an "A" profile. Do "refill check" last 10 minutes of treatment to evaluate plasma refill. |
| | **...Additional Orders** |
| | To be completed by the Hemodialysis nurse.<br>**G0257 Hemodialysis - ESRD** |
| | **90935 Hemodialysis - Non ESRD** |

☐ **TO** ☐ **Read Back** ☐ **Scanned Powerchart** ☐ **Scanned PharmScan**

Order Taken by Signature: _____ Date _____ Time _____

**Physician Signature**: _____ **Date** _____ **Time** _____