attach patient label here

Methodist Le Bonheur Healthcare

Physician Orders ADULT

Order Set: Hemodialysis Adult Orders

[**R**] = will be ordered
T= Today; N = Now (date and time ordered)
Height: _____ cm Weight: _____ kg

Allergies:	[ ] No known allergies
[ ]Medication allergy(s):_____	
[ ] Latex allergy [ ]Other:_____	
Patient Care	
NOTE: If patient has a new AVF/Graph please order QB 250mL/min and 17g needle.	
NOTE: Heparin and Saline MUST be ordered separately in medication section below.	
[ ] Hemodialysis Adult	Requested Start Date/Time:
	Treatment Date: _____ Today _____ Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____ Saturday _____ Sunday
	Treatment Shift: _____ First Shift _____ Second Shift
	Frequency: once
	Length of Treatment: ____2.5hr ____3hr, ____ 3.5hr ____3.75hr ____ 4hr Other_____hr.
	Blood Flow Rate (mL/min): _____250 ____300 ____350 ____400 ____450 ____500, Other:_____
	Dialysate Flow Rate (mL/min): ____500 ____800 _____1.5x Blood Flow Rate Other:_____
	Dialyzer: ___Optiflux 180, Other _____
	Dialysate Bath: __ 2K 2.5CA __ 3K 2.5CA __ 4K 2.25Ca ___1K 2.5CA ___ 3K 3CA ___ 2K 2CA ___ Citrate 1K 2.5CA ___ Citrate 2K 2.5CA ___ Citrate 3K 3CA Other:
	Ultra Filtration: ____1 L/tx, ____1.5 L/tx, _____2 L/tx, ____2.5 L/tx, ____ 3 L/tx, other:
	Use Heparin: Yes or No
	Access Type/Location: (check appropriate blank)
	AV Fistula: ____Brachial R ____Brachial L ____Forearm R ____Forearm L
	AV Graft: ____Brachial R ____Brachial L ____Forearm R ____Forearm L
	Chest Left Chest Right
	Femoral Graft: _____ Right _____ Left
	Tunneled Cath: ____ IJ Right _____ IJ Left ____ Femoral R ____Femoral L
	Temporary Catheter: ____ Femoral R ____Femoral L
	Other Dialysis Access:
	Patient has new Access site: _____No _____ Yes
	Access Needle Size: _____ 15g _____ 16g _____17g, Other:_____
	Isolation Status: _____ Droplet Precautions _____ Contact Precautions _____ Airborne Precautions _____ Special Organisms, Other _____
	Order Comment: Hold ultrafiltration if SBP less than _____.

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Patient Care (continued)		
[ ]	No BP or Venipunctures	T;N, _____Right Arm or _____Left Arm
Nursing Communication		
[ ]	DIALYSIS Nsg Communication	T;N, Do not give patient heparin-Heparin allergy.
[ ]	DIALYSIS Nsg Communication	T;N, Place order for Hep B surface antigen if last result greater than 6 months old
[ ]	Nursing Communication	T;N, GIVE all AM blood pressure medications as ordered on day of dialysis
[ ]	Nursing Communication	T;N, Hold all AM blood pressure medications as ordered on day of dialysis
Continuous infusions		
[ ]	albumin human (albumin, human 25%)	25 g, Injection, Device, Routine, T;N, q15min x 4 doses, PRN; Hypotension, (for 4 doses) Comment: GIVE IN DIALYSIS, Give with Dialysis for systolic BP less than 90, 25 g = 100 mL
[ ]	Sodium Chloride 0.9% (NS Bolus)	250 mL, IV Piggyback, Routine, T;N, q5min x 3, PRN Other, specify in comment (for 3 doses) Comment: GIVE IN DIALYSIS, for systolic BP less than 90.
Medications		
[ ]	Saline Flush	10 mL, Injection, IV Push, PRN, Other, specify in comment, Routine, T;N, Comment: GIVE IN DIALYSIS Flush dialysis line with TEGO connector
	NOTE: If ordering citrasate dialysis bath DO NOT order heparin.	
	NOTE: if heparin desired, please order below	
[ ]	heparin	2,000 units,injection, Device, Routine, T;N, N/A, Comment: GIVE IN DIALYSIS to prime extracorpal circuit and discard.
[ ]	heparin	2,000 units, Injection, Device, Routine, T;N, once, Comment: GIVE IN DIALYSIS at
[ ]	heparin	1,000 units, Injection, Device, Routine, T;N, q1hr, PRN: GIVE IN DIALYSIS, discontinue order at last hour of dialysis
Laboratory		
[ ]	Hematocrit and Hemoglobin	Routine, T;N, once, Type: Blood
[ ]	Hematocrit and Hemoglobin	Routine, T+1;0400, once, Type: Blood
[ ]	Type and Crossmatch PRBC	STAT, T;N, Reason: _____, Transfuse Date Expected: _____, Number of units: _____, Type: Blood, Order Comment Transfuse: during ~~next~~ dialysis treatment.
[ ]	Hold PRBC's	Routine, T;N, Reason for Hold: **Other Specify: Transfuse with ~~next~~ hemodialysis treatment,** Transfusion Date Expected_____, Number of Units Ordered_____, Type: Blood
[ ]	Transfuse PRBC's Not Actively Bleeding	Routine, T;N, Reason for transfusion: Hgb </=7 g/dL or Hct</= 21%_____, H/H </= 8/24 & CAD _____, H/H </= 8/24 & postoperative _____, Tachycardia/hypotens not respond to vol_____, Other Specify_____, Transfusion Date Expected_____, Number of Units Ordered (1), Type: Blood, Comment: Transfuse during dialysis treatment.
	NOTE: If Hep B surface antigen last result is greater than 6 months, please order below	
[ ]	Hepatitis B Surface Antigen	STAT, T;N, Type: Blood

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Consults/ Notifications		
[ ]	Notify Physician - Continuous	T;N, If heart rate is less than 60 bpm or greater than 120 bpm after initiation of dialysis.

Date	Time	Physician's Signature	MD Number
_____	_____	_____	_____