

# Dialysis and Nursing Home Hand-Off COMMUNICATION TOOL

## TO BE COMPLETED BY NURSING HOME AND SENT WITH RESIDENT FOR EACH TREATMENT

Resident Name: \_\_\_\_\_ Date: \_\_\_\_\_ Code Status:     DNR     CPR  
 Vital Signs: T \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ BP \_\_\_\_\_ Baseline Temp: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 Current diet/fluid restrictions: \_\_\_\_\_  
 Last meal or snack and time consumed: \_\_\_\_\_  
 Current type of precautions? (If yes, for what?): \_\_\_\_\_

Contact person at nursing home for change of condition notification or questions: \_\_\_\_\_  
 Nursing Home name: \_\_\_\_\_ Contact number: \_\_\_\_\_

TYPE OF ACCESS:	CHANGES SINCE LAST DIALYSIS TREATMENT	NO <small>(Check N or describe change)</small>	DESCRIPTION OF CHANGE OR EVENT
AV Fistula    AV Graft    Catheter (CVC)			
If Fistula or Graft, can you feel or hear a Bruit or Thrill?	Y    N	N	
CVC dressing dry and intact?	Y    N		
Signs or symptoms of infection	Y    N	N	
<b>DID PATIENT TAKE MEDICATIONS TODAY?</b>			
Blood Pressure	Y    N    N/A		
Insulin	Y    N    N/A	N	
Blood Thinners	Y    N    N/A	N	
Opioids/Sedatives	Y    N    N/A		
<i>(See attached medication list)</i>			
		N	GI bleed, low hemoglobin, other:

## TO BE COMPLETED BY DIALYSIS FACILITY AND RETURNED WITH RESIDENT AFTER EACH TREATMENT

Post treatment vital signs: T \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ BP \_\_\_\_\_  
 Complications/problems during dialysis: \_\_\_\_\_  
 Foods/fluid consumed during dialysis: \_\_\_\_\_ % Meal consumed \_\_\_\_\_ Fluids consumed \_\_\_\_\_  
 Medications given during dialysis: \_\_\_\_\_

Labs drawn	Y    N	Copy attached	Y    N	Pre-dialysis weight		Post-dialysis weight	
New or revised MD orders	Y    N	Copy attached	Y    N	Amount of fluid removed		Time dialyzed	

### Changes, New Recommendations, Notes

Dietitian:
Social work:
Follow-up appointments made or needed:

# NURSING HOME USE ONLY—UPON RETURN TO FACILITY FOLLOWING DIALYSIS

Patient Name: \_\_\_\_\_

Check all that apply	Yes	No	N/A	Dialysis center called for clarification	MD notified	Care plan changed	Nurse supervisor aware	Documentation/ follow-up/new orders
Bruit present								
Thrill present								
Hemodialysis catheter present								
Catheter secured, clamped, and capped								
Access bandage dry and intact								

Vital signs: T \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ BP \_\_\_\_\_

Baseline temp: \_\_\_\_\_ Allergies: \_\_\_\_\_

Additional comments:

Nurse's signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_



This material was prepared by the IPRO QIN-QIO and Alliant Health Solutions, Quality Innovation Network-Quality Improvement Organizations, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication #12SOW-IPRO-QIN-TA-A4-23-1149 [7/26/2023] CP