Ministry of Health Adan Hospital	**DIALYSIS DEPARTMENTS SHIFT–TO-SHIFT NURSING HANDOVER TOOL**	Patient Name :

S

Reason for Admission/ Current Complaint:

Diagnosis:

Type of Access:

AV Fistula (Arm/Leg) (Right/ Left) Permcath (Right/Left)

AV Graft (Arm/Leg) (Right/Left)

Catheter: Intrajugular/Femoral (Right/Left)

PD Catheter:

Age/ Sex : Unit : Nationality:

Bed : Date:

Civil ID :

Nationality: MRN No:

Machine No:

B

Creation Date: Insertion Date :

Isolation Type:	Known Allergies:	Wet Weight:	Hepatitis Markers: HCV Ab ☐ HBsAg ☐ HIV ☐

A

Pre dialysis Assessment	Temp		HR		RR		BP		SPO2	

Physical Assessment:

Neurology LOC______________________ G.C.S_______________ Pain Score______________Others: ___________

Respiratory ☐ Room Air ☐ O2 ___l/min ☐ Tracheostomy Others:____________

Cardiac ☐Cardiac Monitor: Rhythm____________ Others:_____________

Gastrointestinal Diet _________

Genitourinary Intake____________________(ml) Output__________________ (ml)Folley Catheter/ Voiding/ Condom Catheter

Dialysis ____

Others:____

Skin ☐Intact ☐Pressure Sore/ Location _____________ Edema _____________Others:____________

Endocrine: B.Sugar Value________________ Frequency______________ Others: _____________________________

ENT & Ophthal ____

Musculoskeletal ☐ Ambulatory ☐ Bedridden ☐ Paralysis Others:____

Dialysis Order:

Dry Weight:_________kg Target UF:_______ L Isolated UF: _____ Duration: ________hrs

Blood Flow:______.ml/min Dialyzer:__________ Dialyste: Ca ☐ K ☐

Flow : __________ml/min Heparin: Initial Bolus : _________U Infusion:_____________

Medications Given: Aranesp ___________ Ferosac ___________ Others :______________

Investigations : CBC ☐ RFT ☐ SE ☐ PTT ☐ Iron Studies ☐ Others:______________

Post Dialysis Orders:

Recommendations (e.g. Lab orders, Pending Reports,Referrals,Medication,Procedures- Permcath/PD Catheter Insertion,Radiology,Dialyzer etc	

Vaccination Status: Last Received Date

Hepatitis B	
Influenza	
Pneumococcal	
Others(Specify)	

Financial Clearance: Done/Not Done

Extra Session: Day ___________

Month:

No. Of Hours: ___________

Bed Side Safety Check	**Yes /No/ NA**	
Patient ID band present		
Call bell within the reach		
Exit Site Dressings		
Tracing lines & tubes		
Labelling lines and tubes		
Equipment function		
Patient access to mobility aids		
Review medication charts		

Unusual Event:

Risk Management Assessment	**Yes/ NA**	**Score**
Fall Risk		
Decuitus Ulcer		
Suicidal Risk		
VTE Risk		
Restraint Use		

Report completed by... Report Received by...

Sign-out Staff Signature: ________________Sign-In Staff Signature: _______________ Date & Time____________