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: AV Fistula AV Graft Catheter (CVC)	
If Fistula or Graft, can you feel or hear a Bruit or Thrill?	☐ Y ☐ N
CVC dressing dry and intact?	☐ Y ☐ N
Signs or symptoms of infection	☐ Y ☐ N
DID PATIENT TAKE MEDICATIONS TODAY?	
Blood Pressure	☐ Y ☐ N ☐ N/A
Insulin	☐ Y ☐ N ☐ N/A
Blood Thinners	☐ Y ☐ N ☐ N/A
Opioids/Sedatives	☐ Y ☐ N ☐ N/A
(See attached medication list)	

CHANGES SINCE LAST DIALYSIS TREATMENT	**NO** *(Check N or describe change)*	**DESCRIPTION OF CHANGE OR EVENT**
Changes from baseline mental status	☐ N	
New medical problems or falls	☐ N	
Hospitalizations or ED visits	☐ N	
New medications or vaccinations	☐ N	
Labs drawn since last dialysis? (if yes, attach results)	☐ N	
Blood transfusions	☐ N	

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
New or revised MD orders	☐ Y ☐ N	Copy attached	☐ Y ☐ N

Pre-dialysis weight		Post-dialysis weight	
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 IPRO and adapted by Alliant Health Solutions, a Quality Innovation Network – Quality Improvement Organization (QIN – QIO) 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 No. 12SOW-AHS-QIN-QIO-TO1-NH-4406-08/30/23