

CROWNWeb Patient Hemodialysis Worksheet

Use the worksheet below to check-off/write-in patient HD clinical information. These are the minimally required fields to enter clinical information. **Some field selections may make other fields active, and are represented by the arrow going from one selection to the enabled field.**

MEDICATION ALLERGIES	
<div data-bbox="224 457 711 1117"><p>Medication Allergies</p><ul style="list-style-type: none"><input type="checkbox"/> Epoetin Alfa<input type="checkbox"/> Epoetin Beta<input type="checkbox"/> Darbepoetin Alfa<input type="checkbox"/> Iron Dextran<input type="checkbox"/> Sodium Ferric Gluconate<input type="checkbox"/> Iron Sucrose (Venofer)<input type="checkbox"/> Ferrous Fumurate (Feostat, Femlron)<input type="checkbox"/> Ferrous Sulfate (Feosol, Ferlron)<input type="checkbox"/> Calcijex (Calcitriol, Ergocalciferol, Cholecalciferol)<input type="checkbox"/> Zemplar (Paricalcitol)<input type="checkbox"/> Hectorol (Doxercalciferol)<input type="checkbox"/> No known allergies<input checked="" type="checkbox"/> Other</div>	<div data-bbox="802 1045 1399 1297"><p>Other Medication Allergies</p><hr/><hr/><hr/></div>

ADEQUACY	
<div data-bbox="214 1514 721 1644"><p>Interdialytic Time (<i>dd/hh/mm or mm</i>)</p><hr/></div>	<div data-bbox="878 1514 1391 1644"><p>Post Dialysis Weight</p><hr/></div>

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ESA	
<div style="border: 1px solid black; padding: 2px;"> ESA Prescribed <input type="checkbox"/> Yes <input type="checkbox"/> No </div>	<div style="margin-bottom: 10px;"> <div style="border: 1px solid black; padding: 2px;"> ESA Prescribed Date _____ </div> </div> <div style="margin-bottom: 10px;"> <div style="border: 1px solid black; padding: 2px;"> ESA Agent Prescribed <input type="checkbox"/> Epoetin Alfa <input type="checkbox"/> Epoetin Beta <input type="checkbox"/> Darbepoetin Alfa <input type="checkbox"/> Other </div> <div style="border: 1px solid black; padding: 2px; margin-left: 150px; width: 150px;"> Other ESA Agent Prescribed _____ </div> </div> <div style="margin-bottom: 10px;"> <div style="border: 1px solid black; padding: 2px;"> ESA Monthly Dose _____ </div> </div> <div style="margin-bottom: 10px;"> <div style="border: 1px solid black; padding: 2px;"> ESA Unit of Measure <input type="checkbox"/> Units <input type="checkbox"/> mcg <input type="checkbox"/> Other </div> <div style="border: 1px solid black; padding: 2px; margin-left: 150px; width: 150px;"> Other ESA Monthly Dose Measure _____ </div> </div> <div> <div style="border: 1px solid black; padding: 2px;"> ESA Route <input type="checkbox"/> IVP (Intravenous Push) <input type="checkbox"/> SC (Subcutaneous) </div> </div>

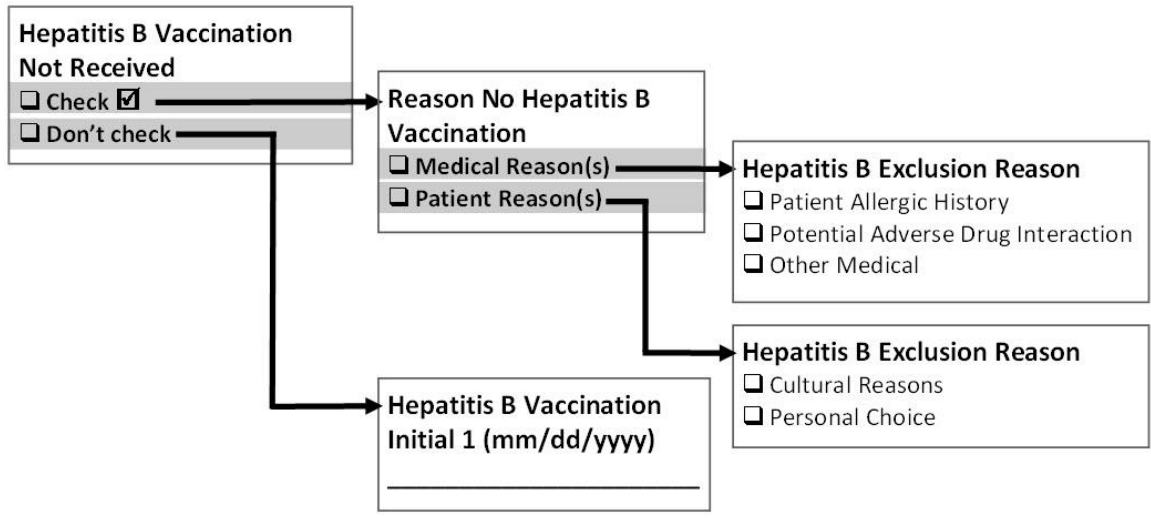
IRON	
<div style="border: 1px solid black; padding: 2px;"> IV Iron Prescribed <input type="checkbox"/> IV Iron Prescribed <input type="checkbox"/> IV Iron Not Prescribed </div>	<div style="margin-bottom: 10px;"> <div style="border: 1px solid black; padding: 2px;"> IV Iron Prescribed Date _____ </div> </div> <div style="margin-bottom: 10px;"> <div style="border: 1px solid black; padding: 2px;"> IV Iron <input type="checkbox"/> Iron Dextran (Dexferrum, Infed) <input type="checkbox"/> Sodium Ferric Gluconate (Ferrlecit) <input type="checkbox"/> Iron Sucrose (Venofer) <input type="checkbox"/> Other </div> <div style="border: 1px solid black; padding: 2px; margin-left: 150px; width: 150px;"> Other IV Iron _____ </div> </div> <div style="margin-bottom: 10px;"> <div style="border: 1px solid black; padding: 2px;"> IV Iron Dose _____ </div> </div> <div> <div style="border: 1px solid black; padding: 2px;"> IV Iron Unit of Measure <input type="checkbox"/> g <input type="checkbox"/> mg <input type="checkbox"/> Other </div> <div style="border: 1px solid black; padding: 2px; margin-left: 150px; width: 150px;"> Other IV Iron Dose Measure <input type="checkbox"/> IVP (Intravenous Push) <input type="checkbox"/> SC (Subcutaneous) </div> </div>

IRON (continued)	
<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> Oral (PO) Iron Prescribed <input type="checkbox"/> Oral Iron Prescribed <input type="checkbox"/> Oral Iron Not Prescribed </div>	<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> Oral (PO) Iron <input type="checkbox"/> Ferrous Fumarate (Feostat, Femiron) <input type="checkbox"/> Ferrous Sulfate (Feosol, FerIron) <input type="checkbox"/> Ferrous Gluconate (Ferate, Fergon, Ferralet, Simron) <input type="checkbox"/> Other </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> Oral (PO) Iron Dose _____ </div> <div style="border: 1px solid black; padding: 5px;"> Oral (PO) Iron Unit of Measure <input type="checkbox"/> g <input type="checkbox"/> mg <input type="checkbox"/> Other </div>
	<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> Other Oral (PO) Iron _____ </div> <div style="border: 1px solid black; padding: 5px;"> Other Oral (PO) Iron Dose Measure _____ </div>

FLUID WEIGHT MANAGEMENT	
<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> Education on Sodium Restriction Not Received <input type="checkbox"/> Check <input checked="" type="checkbox"/> <input type="checkbox"/> Don't check </div>	<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> Date Patient Education on Sodium Restriction _____ </div>
	<div style="border: 1px solid black; padding: 5px;"> Post Dialysis Target Weight for Session <input type="checkbox"/> Prescribed Post-Dialysis Target Weight <input type="checkbox"/> Not Prescribed Post-Dialysis Target Weight </div>

VACCINATION			
Influenza Vaccination Not Received <input type="checkbox"/> Check <input checked="" type="checkbox"/> <input type="checkbox"/> Don't check	Reason No Influenza Vaccination <input type="checkbox"/> Medical Reason(s) <input type="checkbox"/> Patient Reason(s)	Influenza Exclusion Reason <input type="checkbox"/> Patient Allergic History <input type="checkbox"/> Potential Adverse Drug Interaction <input type="checkbox"/> Other Medical	Influenza Exclusion Reason <input type="checkbox"/> Cultural Reasons <input type="checkbox"/> Personal Choice
	Influenza Vaccination Date (mm/yyyy) _____		
	Site Received Influenza Vaccination <input type="checkbox"/> Received in Facility <input type="checkbox"/> Received Outside Facility		
Pneumococcal Vaccination Not Received <input type="checkbox"/> Check <input checked="" type="checkbox"/> <input type="checkbox"/> Don't check	Reason No Pneumococcal Vaccination <input type="checkbox"/> Medical Reason(s) <input type="checkbox"/> Patient Reason(s)	Pneumococcal Exclusion Reason <input type="checkbox"/> Patient Allergic History <input type="checkbox"/> Potential Adverse Drug Interaction <input type="checkbox"/> Other Medical	Pneumococcal Exclusion Reason <input type="checkbox"/> Cultural Reasons <input type="checkbox"/> Personal Choice
	Pneumococcal Vaccination Year (yyyy) _____		

VACCINATION (continued)



VITAMIN D ANALOG

