CROWNWeb Clinical Screens
Peritoneal Dialysis Worksheets

REQUIRED FIELD

THIS SELECTION ENABLES ANOTHER FIELD →

MEDICATION ALLERGIES

***Medication Allergies**
- ❑ Epoetin Alfa
- ❑ Epoetin Beta
- ❑ Darbepoetin Alfa
- ❑ Iron Dextran
- ❑ Sodium Ferric Gluconate
- ❑ Iron Sucrose (Venofer)
- ❑ Ferrous Fumarate (Feostat, Femiron)
- ❑ Ferrous sulfate (Feosol, FerIron)
- ❑ Calcijex (Calcitriol, Ergocalciferol, Cholecalciferol)
- ❑ Zemplar (Parcalcitol)
- ❑ Hectorol (Doxercalciferol)
- ❑ No known allergies
- ❑ **Other** →

Other Medication Allergies
_____

NOTE: *Medications may be separated by commas; field allows 100 characters maximum.*

ANEMIA MANAGEMENT

Hgb (g/dL)
_____ _____
Date

TSAT (%)
_____ _____
Date

Ferritin (ng/mL)
_____ _____
Date

Reticulocyte Hemoglogin (CHr) (pg)
_____ _____
Date

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ADEQUACY

Weekly Kt/V

_____

_____

Date

V Method (PD)
- ❑ % Body Weight
- ❑ Hume
- ❑ Watson
- ❑ Other

NOTE: *If facility default preferences are set for this field, then **Kt/V** field will be required in order to submit clinical data. De-select this field to allow **Kt/V** to submit with no data.*

Height

_____

- ❑ in
- ❑ cm

Clinic Weight

_____

- ❑ lbs
- ❑ kg

BSA Method (PD)
- ❑ Dubois and Dubois
- ❑ Other

RRF Assessed in Kt/V
- ❑ Yes
- ❑ No

Prescription Change after Adequacy Measurement
- ❑ Yes
- ❑ No

24hr Dialysate Volume (mL)

_____

Clinic Weight

_____

- ❑ lbs
- ❑ kg

Serum BUN (mg/dL)

_____

24hr Dialysate Urea Nitrogen (mg/dL)

_____

24hr Dialysate Creatinine (mg/dL)

_____

Creatinine Clearance

_____

- ❑ L/wk
- ❑ L/wk/1.73m^2

BSA Corrected
- ❑ Yes
- ❑ No

24hr Urine Volume (mL)

_____

24hr Urine Creatinine (mg/dL) _____

24hr Urine Urea Nitrogen (mg/dL) _____

Serum Creatinine (mg/dL)

_____ _____

Date

*Date must be same as **Weekly Kt/V** Date.*

Normalized Protein Catabolic Rate (nPCR)

_____ _____

NNN.NN **Date**

Residual Renal Function Testing Performed
- ❑ Received from Lab
- ❑ Not Received from Lab

Creatinine Clearance

_____

- ❑ L/wk
- ❑ L/wk/1.73m2

IRON

***Intravenous (IV) Iron Prescribed**
- ❑ **IV Iron was Prescribed** → **Intravenous (IV) Iron**
- ❑ IV Iron was not Prescribed

_____
Date

Intravenous (IV) Iron
- ❑ Iron Dextran (Dexferrum, Infed)
- ❑ Sodium Ferric Gluconate Ferrlecit)
- ❑ Iron Sucrose (Venofer)
- ❑ **Other** → **Other Intravenous (IV) Iron**

Intravenous (IV) Iron Dose

_____
- ❑ g
- ❑ mg
- ❑ **Other** → **Other Intravenous (IV) Iron Dose Measure**

_____

Other Intravenous (IV) Iron

_____ → **Intravenous (IV) Iron Dose**

_____
- ❑ g
- ❑ mg
- ❑ **Other** → **Other Intravenous (IV) Iron Dose Measure**

_____

***Oral (PO) Iron Prescribed**
- ❑ **Oral Iron Prescribed** → **Oral (PO) Iron**
- ❑ Oral Iron was Not Prescribed

Oral (PO) Iron
- ❑ Ferrous Fumarate (Feostat, Femiron)
- ❑ Ferrous Sulfate (Feosol, FerIron)
- ❑ Ferrous Gluconate (Ferate, Fergon, Ferralet, Simron)
- ❑ **Other** → **Other Oral (PO) Iron**

Oral (PO) Iron Dose

_____
- ❑ g
- ❑ mg
- ❑ **Other** → **Other Oral (PO) Iron Dose Measure**

_____

Other Oral (PO) Iron

_____ → **Oral (PO) Iron Dose**

_____
- ❑ g
- ❑ mg
- ❑ **Other** → **Other Oral (PO) Iron Dose Measure**

_____

VITAMIN D ANALOG

***Oral Vitamin D Analog Prescribed**
- ❑ **Oral Vitamin D Analog Prescribed**
- ❑ Oral Vitamin D Analog Not Prescribed

Oral Vitamin D Analog
- ❑ Calderol
- ❑ Delta D3
- ❑ DHT Intensol
- ❑ DHT
- ❑ Drisdol
- ❑ Hectorol
- ❑ Rocaltrol
- ❑ Vitamin D3
- ❑ Vitamin D2
- ❑ Zemplar
- ❑ **Other**

Oral Vitamin D Analog Dosage

_____
- ❑ mcg
- ❑ IU

Other Oral Vitamin D Analog

_____

Oral Vitamin D Analog Dosage

_____
- ❑ mcg
- ❑ IU

Serum Parathyroid Hormone Type
- ❑ Intact PTH (iPTH)
- ❑ Not applicable
- ❑ Other

Other Serum Parathyroid Hormone Type

_____

Serum Parathyroid Hormone (PTH) Value (pg/mL)

_____ _____
Date

MINERAL METABOLISM

Pho (mg/dL)

_____ _____
Date

Corrected Ca (mg/dL)

_____ _____
Date

Serum Albumin (g/dL)

_____

_____
Date

Serum Albumin Lower Limit (g/dL)

_____

Serum Albumin Lab Method
- ❑ BCG
- ❑ BCP

Uncorrected Ca (mg/dL)

_____ _____
Date

HOSPITALIZATION

Admission From Dialysis Facility
- ❑ **Sent to hospital directly from Dialysis facility** → **Admission Date** _____
- ❑ Not Sent to hospital directly

These fields are only required IF the patient is hospitalized.

All Hospital Visits
- ❑ Emergency Department Visit
- ❑ Hospitalization
- ❑ Emergency Department visit Resulted in a Hospital Admission

Name of Hospital
_____

Admission Diagnosis
- ❑ Cardiovascular
- ❑ Neurological
- ❑ Musculoskeletal
- ❑ Respiratory
- ❑ Genitourinary
- ❑ Gastrointestinal
- ❑ Endocrine
- ❑ Sepsis
- ❑ Vascular Access Related
- ❑ **Other** → **Other Admission Diagnosis** _____

Advanced Directives
- ❑ DNR (Do not Resuscitate)
- ❑ DNI (Do not intubate)

Discharge Diagnosis *[ICD Code & Description]*
_____ → **Discharge Date** _____

Source of Admission Information
- ❑ Electronic Database
- ❑ Patient
- ❑ **Other** → **Other Source of Admission Information** _____

Transplant Referral
- ❑ Transplant Referral
- ❑ Not a Transplant Referral

Transplant Waiting List
- ❑ On a Transplant Waiting List
- ❑ Not on a Transplant Waiting List

Hospitalization Due to Presumptive Diagnosis
- ❑ Patient was hospitalized due to a presumptive diagnosis
- ❑ Patient was not hospitalized due to a presumptive diagnosis

FLUID WEIGHT MANAGEMENT

Education on Sodium Restriction Not Received
❑ Check ☑
❑ **Don't check** → **Date Patient Education on Sodium Restriction**
_____

[Required if received]

Home Blood Pressure Values Provided
❑ Provided Home Blood Pressure Values
❑ Did Not Provide Home Blood Pressure Values

Home Blood Pressure Status
❑ Low
❑ High
❑ Standard Deviation

Dry Weight Order
❑ Prescribed Dry Weight Order
❑ Not Prescribed Dry Weight Order

Presence of Edema
❑ Physical Presence of Edema
❑ No Physical Presence of Edema

Physical Presence of Abnormal Breath Sounds
❑ Physical Presence of Abnormal Breath Sounds
❑ No Physical Presence of Abnormal Breath Sounds

Echocardiogram Date
_____ → **Presence of Left Ventricular Hypertrophy**
❑ Shows Left Ventricular Hypertrophy
❑ Does Not Show Left Ventricular Hypertrophy

Change in Left Ventricular Hypertrophy
❑ Shows Change in Left Ventricular Hypertrophy
❑ Does Not Show Change in Left Ventricular Hypertrophy

INFECTION

Date Access Infection Confirmed
_____

Site of Dialysis Access Infection
- ❑ PD—Catheter
- ❑ Not Access Related

Outpatient Antibiotics Administered
- ❑ Antibiotic Therapy was prescribed
- ❑ Antibiotic Therapy was not prescribed

Antibiotic Name
_____

Date Antibiotic Prescribed
_____

Antibiotic Dose
_____
- ❑ mg
- ❑ g
- ❑ Other

Other Antibiotic Dose Measurement
_____

Antibiotic Frequency
- ❑ QID
- ❑ TID
- ❑ BID
- ❑ Daily
- ❑ Weekly
- ❑ Other

Other Antibiotic Frequency
_____

Blood Culture Result
- ❑ **Positive Culture**
- ❑ **Negative Culture**
- ❑ **Unknown**

Indicate Organisms of Positive Culture
_____

Blood Culture Date
_____

Antibiotic Route
- ❑ Oral
- ❑ Intravenous (IV)
- ❑ Intramuscular (IM)
- ❑ **Other**

Other Antibiotic Route
_____

Infection Requires Hospitalization
- ❑ **Infection requires hospitalization**
- ❑ Infection does Not require hospitalization

Infection Hospitalization Date
_____

Symptoms of Clinical Sepsis (fever [>38◦C], rigors, blood pressure drop, alternate blood pressure drop, altered mental status)
- ❑ Patient has symptoms of clinical sepsis
- ❑ Patient does not have symptoms of clinical sepsis

Signs of Soft Tissue Infection (pus OR exudates, and at least two of the following: redness, pain or swelling)
- ❑ Patient has signs of soft tissue infection
- ❑ Patient does not have signs of soft tissue infection

Result of Peritoneal Dialysis Effluent Analysis
- ❑ Peritoneal dialysis effluent cell counts/differential indicative of possible infection
- ❑ Peritoneal dialysis effluent cell counts/differential Not indicative of possible infection
- ❑ Peritoneal dialysis effluent cell counts/differential Not performed

Peritoneal Dialysate Culture Results
- ❑ Peritoneal dialysis culture was positive
- ❑ Peritoneal dialysis was negative
- ❑ Peritoneal dialysis was not performed

VACCINATION

Influenza Vaccination Not Received
- ❑ Check ☑
- ❑ Don't check

[Required if received]

Reason No Influenza Vaccination
- ❑ Medical Reason(s)
- ❑ Patient Reason(s)

Influenza Exclusion Reason
- ❑ Patient Allergic History
- ❑ Potential Adverse Drug Reaction
- ❑ Other Medical

Influenza Exclusion Reason
- ❑ Cultural Reasons
- ❑ Personal Choice

Influenza Vaccination Date

_____

Site Received Influenza Vaccination
- ❑ Received in Facility
- ❑ Received Outside Facility

Pneumococcal Vaccination Not Received
- ❑ Check ☑
- ❑ Don't check

[Required if received]

Reason No Pneumococcal Vaccination
- ❑ Medical Reason(s)
- ❑ Patient Reason(s)

Pneumococcal Exclusion Reason
- ❑ Patient Allergic History
- ❑ Potential Adverse Drug Reaction
- ❑ Other Medical

Pneumococcal Exclusion Reason
- ❑ Cultural Reasons
- ❑ Personal Choice

Pneumococcal Vaccination Year

_____

Hepatitis B Vaccination Not Received
- ❑ Check ☑
- ❑ Don't check

[Required if received]

Reason No Hepatitis B Vaccination
- ❑ Medical Reason(s)
- ❑ Patient Reason(s)

Hepatitis B Exclusion Reason
- ❑ Patient Allergic History
- ❑ Potential Adverse Drug Reaction
- ❑ Other Medical

Hepatitis B Exclusion Reason
- ❑ Cultural Reasons
- ❑ Personal Choice

Hepatitis B Vaccination Initial 1

_____
mm/dd/yyyy

Hepatitis B Vaccination Initial 2

_____
mm/dd/yyyy

Hepatitis B Vaccination Initial 3

_____
mm/dd/yyyy

Hepatitis B Vaccination Initial 4

_____
mm/dd/yyyy

TO NEXT PAGE

VACCINATION (cont.)

FROM PREVIOUS PAGE

Hepatitis B Test Type (HBsAg)
- ❑ HBsAg (Hepatitis B surface antigen)
- ❑ Anti-HBc (Antibody to hepatitis B core antigen)
- ❑ Anti-HBs (Antibody to hepatitis B surface antigen)
- ❑ IgM Anti-HBc (Antibody sub-class of anti-HBc)
- ❑ Other → **Other Hepatitis B Test Type** _____

_____
Date

Anti-HBs (mIU/ml)
_____ _____
Date

Hepatitis C Screen Test
- ❑ Enzyme Immunoassay (EIA) Standard
- ❑ Enhanced Chemiluminescence Immunoassay (CIA)
- ❑ Recombinant Immunoblot Assay (RIBA)
- ❑ **Other** → **Other Hepatitis C Screen Test** _____

_____
Date

Hepatitis B Booster Date 1
_____
mm/dd/yyyy

Hepatitis B Booster Date 2
_____
mm/dd/yyyy

Hepatitis B Booster Date 3
_____
mm/dd/yyyy

Hepatitis B Booster Date 4
_____
mm/dd/yyyy

ESA

***ESA Prescribed**
- ❑ **Yes**
- ❑ No

_____
Date

ESA Agent Prescribed
- ❑ Epoetin Alfa
- ❑ Epoetin Beta
- ❑ Darbepoetin Alfa
- ❑ **Other** → **Other ESA Agent Prescribed** _____

ESA Monthly Dose
_____
- ❑ Units
- ❑ mcg
- ❑ **Other** → **Other ESA Monthly Dose Measure** _____

ESA Route
- ❑ IVP (Intravenous Push)
- ❑ SC (Subcutaneous)