



Confidential Summary and Data Collection Sheet

Please complete this form for every patient who has HD in your unit in the census period. This includes patients who are normally registered with another unit but who are dialysing with you on those days. It also includes all your satellites.

An instruction sheet has been sent to each renal unit and can be viewed on the Website.

Once complete, please return to your SRR unit contact and the SRR staff will arrange for the forms to be returned to the SRR office via a courier. Thank you.

1. Patient ID Attach Patient ID Label Here	Name of parent renal unit – refer to list
	Location of the HD eg home or Satellite unit refer to list

2. HD Details

Date of HD reported for this census	<input type="text"/> <input type="text"/> . 05. 2016 (DD.MM.YYYY)
HD sessions per week	<input type="text"/> (enter 1 – 7)
What is the planned duration of this HD session	<input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> (hh:mm)
Ultrafiltration Volume	<input type="text"/> : <input type="text"/> <input type="text"/> (L)
Is the patient receiving HDF?	Yes <input type="checkbox"/> No <input type="checkbox"/>

3. Today's pre and post dialysis weight, blood pressure and height

Please record the patient's pre dialysis weight, wearing light indoor clothes with shoes .	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> kg
Please record the patient's post dialysis weight, wearing light indoor clothes with shoes .	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> kg
Please record the patient's pre dialysis sitting blood pressure	<input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> mmHg
Please record the patient's post dialysis sitting blood pressure	<input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> mmHg
Please record the patient's height	<input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> m
For new patients who have commenced RRT within last year: ie May 2014 – May 2016 Please enter pre and post weight at first dialysis or nearest to first dialysis and the date the weights were recorded.	Pre <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> kg Post <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> kg Date <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DD.MM .YYYY
Has the patient had a lower limb amputation? If Yes	Yes <input type="checkbox"/> No <input type="checkbox"/> Unilateral <input type="checkbox"/> Bilateral <input type="checkbox"/>

4. Calcium, Phosphate, PTH, Haemoglobin, Ferritin and URR Audits

Please ensure that appropriate samples have been sent for these audits.

Has the patient had a blood transfusion in the 28 days before the Hb audit sample?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>
If "Yes" Date of transfusion	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> . 2016		
Units Transfused	<input type="text"/> <input type="text"/>		

5. Vascular Access

Please tick one box, which best describes the afferent (arterial) access used for HD.

Fistula:	Right	Left
Radiocephalic		
Brachiocephalic		
Brachiobasilic		
Ulnacephalic		
Radioulnar		
Popliteal to long saphenous		
AV Fistula details not known		

Graft:	Right	Left
Radial artery to antecubital vein		
Brachial artery to axillary vein		
Brachial artery to brachial vein		
Brachial artery to cephalic vein		
Brachial artery to basilic vein		
Axillary artery to axillary vein		
Femoral artery to femoral vein		
Popliteal artery to internal jugular vein		
Popliteal artery to femoral vein		
Axillary artery to jugular vein		
Femoral artery to jugular vein		
Femoral artery to renal vein		
AV Graft details not known		

Vein Loop	Right	Left
Brachial artery to brachial vein		
Brachial artery to basilic vein		
Femoral artery to femoral vein		
Vein Loop details not known		

Non Tunnelled CVC Catheters ("Lines")	Right	Left
Non tunnelled internal jugular vein catheter		
Non tunnelled subclavian vein catheter		
Non Tunnelled femoral vein catheter		
Non Tunnelled Line details not known		

Tunnelled CV Catheters ("Lines")Line	Right	Left
Tunnelled internal jugular vein catheter		
Tunnelled subclavian vein catheter		
Tunnelled femoral vein catheter		
Subcutaneous Implanted eg "LifeSite"		
Tunnelled Line details not known		

Needed but details not known	Right	Left
Needles used through the skin but access type not known		

Has the patient been cannulated using the buttonhole technique?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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Additional Comments: (if required to explain a complex situation that is not covered in the list above)

6. Haemopoietic Drugs

Please insert the prescription that is in force for the following medicines on the Census Day. **Insert "0" dose for medicines which are not prescribed. A dose or a "0" should be entered in every box in the dose column.**

Drug Name	Dose	Units		Frequency	Route		
		microg	Mg		sub cut	IV	Oral
Example Epo	1000	ü		fortnightly	ü		
Example Darbepotein	0						
Example Iron	75		ü	weekly			ü
Complete Below							
Epo (Alfa or Beta, aka Epoetin, Eprex NeoRecormon)							
Darbepotein (aka Arenesp, Darbepotein Alfa, Nesp)							
MIRCERA							
Iron Sucrose, (aka Iron Saccharate, Venofer)							
Iron Dextran (aka CosmoFer)							
Iron Sorbitol (aka Jectofer)							
Other (specify)							