



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. 2017 (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

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"/>
For NEW patients who have commenced RRT within last year: ie May 2016 – May 2017 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
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

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"/> . 2017		
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.

AV Fistula:		
Radiocephalic		
Brachiocephalic		
Brachiobasilic		
Thigh		
AVF Detail not known		

AV Graft:		
Forearm (Radial artery)		
Upper arm (Brachial artery)		
Chest wall (Axillary artery)		
Thigh (Femoral artery)		
AVG Detail not known		

Tunnelled CVC (line)		
Internal jugular		
Subclavian		
Femoral		
Other : Specify below		
Detail not known		

Non-tunnelled CVC (line)		
Internal jugular		
Subclavian		
Femoral		
Other : Specify below		
Detail not known		

Has the patient's AV fistula been cannulated using the buttonhole technique?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
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Has the patient been dialysed using both AV access and CVC during this session?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
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Additional Comments/ Specification of 'Other' access:	
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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	✓		fortnightly	✓		
Example Darbepotein	0						
Example Iron	75		✓	weekly			✓
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)							

7. Phosphate Drugs

Could you ask the patient:

Are you taking one or more phosphate binder tablets?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>
Do you take Alfacalcidol, Calcitriol or other Vitamin D supplement?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>
Do you take Cinacalcet(Mimpara)?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>
Have you had surgery to remove one or more of your parathyroid glands?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>