Scottish Renal Registry

Annual Audit Census Day May 2018 - HD

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	☐☐**. 05. 2018** (DD.MM.YYYY)
HD sessions per week	☐ (enter 1 – 7)
What is the planned duration of this HD session	☐☐ **:** ☐☐ (hh:mm)
Ultrafiltration Volume	☐ **:** ☐☐ (L)
Is the patient receiving HDF?	Yes ☐ No ☐

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

Has the patient had a lower limb amputation? If Yes:	Yes ☐ No ☐ Unilateral ☐ Bilateral ☐
For **NEW** patients who have commenced RRT **within last year: ie May 2017 – May 2018** Please enter pre and post weight at first dialysis or nearest to first dialysis and the date the weights were recorded.	Pre ☐☐☐. ☐ kg Post ☐☐☐. ☐ kg Date ☐☐.☐☐.☐☐☐☐ **DD.MM .YYYY**
Please record the patient's pre dialysis weight, wearing light indoor clothes **with shoes**.	☐☐☐**.** ☐ kg
Please record the patient's post dialysis weight, wearing light indoor clothes **with shoes**.	☐☐☐**.** ☐ kg
Please record the patient's pre dialysis sitting blood pressure	☐☐☐**/** ☐☐☐ mmHg
Please record the patient's post dialysis sitting blood pressure	☐☐☐**/** ☐☐☐ mmHg
Please record the patient's height	☐**.**☐☐☐ 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 ☐	No ☐	Don't know ☐
If "Yes" Date of transfusion Units Transfused	☐☐.☐☐**. 2018** ☐☐		

This is a 2 sided form please ensure both sides are completed and returned to your unit contact – Thank you.

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 (Axilliary artey)		
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 ☐ No ☐ N/A ☐

Has the patient been dialysed using both AV access and CVC during this session?	Yes ☐ No ☐ N/A ☐

Additional Comments/ Specification of 'Other' access:	

6. Drugs

Erythropoesis stimulating agent (ie epo, aranesp or other)	Yes ☐ No ☐ Don't know ☐
Iron Sucrose, (aka Iron Saccharate, Venofer or other)	Yes ☐ No ☐ Don't know ☐
Phosphate Binders	Yes ☐ No ☐ Don't know ☐

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