LAKELAND DIALYSIS LIMITED

DIALYSIS PRESCRIPTION

Name	DoB	Treatment mode HD HDF	Treatment Time Hrs Mins
Hi-Flux Cordiax Dialyser **FX60** (1.4M2) **FX80** (1.8M2) **FX100** (2.2M2) If a different dialyser is required, please state and supply.			
The **only** Dialysis Fluid we provide contains **Calcium 1.25mmols per litre and Glucose 1g/l**		With 1.0mmol of Potassium Y/N	With 2.0mmols of Potassium Y/N
Heparin 1000iu per ml	Bolus	Hourly infusion Rate	Stop Time
Other Anticoagulant	Please Supply		
Sodium set at **138** Or state other	Sodium Profile Start End	UF Profile	Bicarbonate set at **35** Or state other
Site of Fistula / Graft Left / Right		Site of Venous Line Left / Right	
Needle Size g Number x2 x1 Button Hole Y / N (If Yes Please Supply)		Single Lumen Y/N Double Lumen Y/N	
Usual effective Blood flow Usual Dialysate flow Usual Arterial pressure Usual Venous pressure		Line Lock of 5000iu Heparin per ml equal to the length of the lumen Volume required A= V= If Other Please State-	
Dry Weight Average Weight Gain		Average Pre BP Average Post BP	
Please write here PRESCRIPTION for medication required on dialysis**. Do not write see attached.**			
MEDICATION	Route	Frequency	Dose
Paracetamol 1g as required Substitution Fluid / Saline 0.9% as required		Lidocaine 1% s/c to fistula site as required	
Possible Complications whilst on Dialysis-			
Medical History in Brief			
Allergies			
If alternative anticoagulant is not sent with the patient, HEPARIN 1000iu bolus and 1000iu hourly rate will be administered unless otherwise stated.			
I certify that the above information is correct, that this patient is stable on dialysis, and medically fit to be dialysed in a nurse led clinic.			
Name of **DOCTOR / NURSE PRESCRIBER** ** ** Date Signed / / 2018 Signature ** **			

All information will be kept confidentially under the
General Data Protection Regulation 2018.

Tel 01900 822 888 Fax 01900 822 155