

Fax Transmittal

Date: _____

To: _____

Fax: _____

From: _____

Phone: _____ **Department / Unit:** _____

Fax: _____ **E-mail:** _____

Patient: _____

	Current	Recom- mended	Agree (<input type="checkbox"/>)	Disagree/Recommend (<input type="checkbox"/>)
Dry Weight	_____	_____	_____	_____
Heparin Dose	_____	_____	_____	_____
K+ (lab result)	_____	_____	_____	_____
Dialysate	_____	_____	_____	_____
Potassium	_____	_____	_____	_____
Calcium	_____	_____	_____	_____
Na Modeling	_____	_____	_____	_____
spKT/V	_____	_____	_____	_____
Time	_____	_____	_____	_____
QB	_____	_____	_____	_____
Dialyzer	_____	_____	_____	_____
Recirculations	_____	_____	_____	_____
EPO	_____	_____	_____	_____
Hemoglobin	_____	_____	_____	_____
Zemplar	_____	_____	_____	_____
Blood Pressure	_____	_____	_____	_____
Patient No Show	_____	_____	_____	_____
Comments:	_____			

RN/LPN Name & Signature

Physician Name & Signature

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