Non- Citrate CVVH prescription- Ward 215

Date_____ Name_____ DOB_____ Pt Weight (kg) _____

Filter used _____ Access _____ Dressing Change _____ Device number _____

Exchange/hr _____ ___ Type Fluid _____ _____ Blood Flow _____

(Exchange /hr – minimum 2600mls/hr or approx 35ml/kg/hr / Fluid type MultiBic 4 or 2 - serum K / Blood Flow >250mls/hr)

Anticoagulant (Circle)– Nil / Heparin Heparin Strength – 250iu / 500iu / 1000iu per ml

Pre-anticoagulation ACT _____ Target _____ Machine No _____

Prime Fluid (circle)- 0.9% saline / HAS Straight connect (Y/N) ___ Washback removed (Y/N)___

Prescribed by (DR) (capitals)

Sign On 1st Nurse (capitals)

Sign on 2nd Nurse (capitals)

Time	BP	HR	AP	RP	TMP	Blood Flow	Pre/post Exch rate	Total Excha	Fluid loss total	ACT	AC rate	AC Bolus	AC level	CC	Initials

Circuit Check to be completed as required but minimal hourly during treatment / tick CC – 2nd last column