



## Personal PD Prescription

Complete this form for each cyclor patient for initial prescription and for any prescription changes. Patient can use this form to check the prescription or to program their cyclor.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

TREATMENT SETTINGS AND OPTIONS:	Fill in amount or circle answer below
# FILLS	
# PAUSES	
PAUSE VOL	
CCPD VOL	
LAST FILL	
FILL TIME	
DWELL TIME	
DRAIN TIME	
FAST FILL/DRAIN	YES or NO
LAST BAG ALARM	YES or NO
PREWARM BAGS	YES or NO
RX START TIME	_____ AM or PM
TIDAL SETTINGS	
TIDAL THERAPY	YES or NO
FIRST FILL	
TIDAL FILL	
TIDAL DRAIN	
OTHER OPTIONS	
SCREEN BLANKING	YES or NO
LANGUAGE	ENGLISH SPANISH FRENCH
ALLOW > 3 LITERS	YES or NO
WEIGHT UNITS	LBS or KGS
ADD DIURNAL UF?	YES or NO

Checked by: \_\_\_\_\_

Date: \_\_\_\_\_



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