**Acute Kidney Injury Discharge Template and/or Nephrology sign-off note:** provide copy to patient’s primary care provider and to patient/family/caregiver

Red font: need to fill in patient details.

The above named person was admitted to hospital and developed [mild/moderate/severe] acute kidney injury (AKI) secondary to [xxxx].

* Highest creatinine in the hospital: xx umol/l. (date)
* The patient [did/did not] receive acute dialysis during the hospital stay
* Baseline creatinine: xxx umol/L (eGFR xx ml/min/1.73 m2) (date)
* Most recent creatinine:  xx umol/L  (eGFR xx ml/min/1.73 m2) (date)
* Most recent urine albumin-to-creatinine ratio (ACR): yy  mg/mmol. (date)

AKI has several health consequences, including increased risks of recurrent AKI episodes, progression to chronic kidney disease, cardiovascular disease, respiratory disease, and mortality.

**Follow-up recommendations:** (check one of the following)

[ ] High risk of AKI complications: e.g. heart failure, poor kidney recovery, or moderate recovery with history of cardiovascular disease, critical care, cancer, history of recurrent AKI, or frailty

**Recommendation:** Serum creatinine and outpatient follow up for clinical review/blood pressure assessment within 1-2 weeks of discharge if possible, and urine ACR 3 months post-discharge

[ ] Moderate risk of AKI complications: e.g. moderate recovery, or good kidney recovery with history of cardiovascular disease, critical care, cancer, history of recurrent AKI, frailty

**Recommendation:** Serum creatinine testing and outpatient follow up for clinical review/blood pressure assessment within 1 month of discharge, and urine ACR 3 months post-discharge

[ ] Low risk of AKI complications: good kidney recovery and no significant risk factors for AKI complications

**Recommendation:** Serum creatinine and urine ACR testing and outpatient follow up for clinical review/blood pressure assessment within 3 months of discharge

**Medication management:**

Medicines that were changed/held during hospitalisation which require re-evaluation post-discharge include:

(Insert ‘medications table’ from EMR or enter manually)

a)

b)

Please refer to (Link to Medication Guidance Table) for guidance on medication management. In general, RAASi and SGLT-2i, should be restarted when steady-state renal function is achieved, if there are no contraindications. Nephrotoxic medications such as non-steroidal anti-inflammatory drugs (ibuprofen, naproxen, diclofenac) should be avoided.

**Referral recommendations:**

They should be referred to a nephrologist if there is persistently reduced eGFR <45 ml/min/1.73 m2 or persistent decline in eGFR more than 50% from baseline, or urine ACR >30 mg/mmol. If you have any questions, contact your local nephrologist or the Rapid Access to Consultative Expertise (RACE) line, 604-696-2131/toll free: 1-877-696-2131.

**Additional information:**

Additional resources for management of post-acute-kidney-injury are available through BC Renal (Link to Toolkit for HealthCare Providers). A patient handout on acute kidney injury was provided to the patient and is also available at (Link to 1pg Patient Flyer).