In R.D.T. it is easy to accumulate vast volumes of clinical documentation from which it is sometimes difficult to extract the relevant information.

Three charts designed to simplify record keeping are shown. They are kept in each patient’s own loose-leaf folder.

**Chart 1**

This allows the records of a week’s dialysis to be entered. Should any dialysis be unusual the sheet is retained, otherwise the sheet is destroyed after the significant data are transferred to Chart 2 (Fig. 1).

![Chart 1](image)

**Fig. 1**

**Chart 2**

This covers a month of dialysis. Its particular value is that it allows the recording of biochemical and haematological data, so that laboratory chits can be destroyed (Fig. 2).
**Chart 4**

This chart allows a uniform clinical follow-up, acting as an aid for the less experienced physician, and an aide-mémoire for the expert (Fig. 3).
### Patient's card

Patients receiving complex and potentially dangerous therapy should carry relevant information on their person. This blue card supplies information which might be useful in an emergency (Fig. 4).