A SHARED PATIENT + CLINICIAN TOOL · AKI RECOVERY

AKI/AKD 90-Day Recovery Planner

Fill this in **with your clinician.** It records your baseline, your recovery trajectory, and a clinician-approved plan for every medicine — through Day 90.

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0–90	Day 90	Every med
Days: the recovery window after AKI	Check both kidney function AND damage	Has a named prescriber & monitoring date

1 My Kidney Event & Clinician Handoff

Patient name / identifier			
Preferred contact		**Admission date**	
Discharge date		**AKI stage (1 / 2 / 3 / unknown)**	
Suspected cause(s) of AKI — tick all that apply			
☐ Sepsis / infection ☐ Dehydration / GI loss ☐ Heart failure ☐ Surgery ☐ Obstruction ☐ Medication / toxin ☐ Dengue ☐ Leptospirosis ☐ Glomerular disease ☐ Pregnancy-related ☐ Other / uncertain			
Baseline SCr / eGFR & date		**Baseline uncertain?**	☐ Yes — baseline unknown
Peak SCr & date		**Lowest urine output (if known)**	
Kidney replacement therapy (KRT / dialysis) used?			
☐ No ☐ Yes — modality _____, start date ____, last treatment ____ or ☐ ongoing			
Discharge numbers			
SCr / eGFR		**Potassium (K)**	
Bicarbonate (HCO_3 / total CO_2)		**Blood pressure (BP)**	
Weight / volume status		**Urine output & date**	
Recovery category *KDIGO 2026 draft definition*	☐ Complete ☐ Partial ☐ Not resolved ☐ Indeterminate		
Named follow-up clinician / team & contact			
Nephrotoxins / exposures to avoid			

This is a clinician–patient shared document, not a self-treatment protocol. Every medication action in this planner needs a named prescriber. Do not start, stop, or change any prescription medicine on your own. Recovery definitions marked "draft" come from the March 2026 KDIGO AKI/AKD public-review draft and are proposed, not final.

For educational use only. This planner does not replace individualized medical advice. It is completed together with your clinician, who owns every medication and monitoring decision.

My 0–90-Day Recovery Road Map

Milestones from discharge to the Day-90 decision · fill in your own dates

Your clinician decides which reviews you need and when. Earlier review is for higher-risk recovery; everyone with a meaningful AKI needs the Day-90 check. Write your planned date, place, and clinician for each milestone, then tick it off when done.

DAY 0 · DISCHARGE
Passport complete; medicines and follow-up plan in hand.
Date _____
Done ☐

DAYS 1–7 · SAFETY CHECK
Volume, BP, potassium, medicine tolerance. Home monitoring daily.
Date _____ Clinician _____
Done ☐

DAYS 7–14 · EARLY REVIEW
For higher-risk patients (stage 2–3, KRT, HF, dynamic labs, meds restarted).
Date _____ Clinician _____
Done ☐

DAY 30 · TRAJECTORY & MEDS
Repeat kidney function; titrate and monitor indicated medicines.
Date _____ Clinician _____
Done ☐

DAY 60 · UNRESOLVED-AKD CHECKPOINT
If still abnormal (AKD), reassess actively — do not just wait for Day 90.
Date _____ Clinician _____
Done ☐

DAY 90 · THE DECISION
Kidney function + kidney damage + CKD decision (see page 8).
Date _____ Clinician _____
Done ☐

Milestone	Planned date	Location	Clinician	Labs before visit / result & action
Days 1–7				
Days 7–14				
Day 30				
Day 60				
Day 90				

Feeling better is not the same as completing follow-up. Keep every appointment even if you feel well.

Timepoint	Date	SCr (mg/dL)	eGFR · steady? (Y/N/?)	Cystatin C	K · HCO_3 · Na	UACR / UPCR	Urinalysis / blood	24-h urine / clearance (if AKI-D) · clinician note
Baseline								
Peak (worst)								
Discharge								
Day 7								
Day 14								
Day 30								
Day 60								
Day 90								
Other								
Other								

How to read this tracker

eGFR is only reliable when creatinine is steady — mark "N" or "?" if it is still rising or falling fast, and treat that eGFR as informational only. Do not colour a single creatinine "green" without looking at your baseline and the trend. A urine test for protein (UACR) matters even when creatinine improves. Optional unit note: 1 mg/dL creatinine = 88.4 µmol/L.

Medicine (generic / brand)	Original indication	Action	Reason & restart-readiness criteria	Planned date	Dose	Responsible prescriber	Lab / BP monitoring date	Actual action / outcome
ACEi / ARB / ARNI								
SGLT2 inhibitor								
Diuretic (loop / thiazide)								
MRA								
Metformin								
Insulin / sulfonylurea								
NSAID (avoid if able)								
Antibiotic / antiviral								
Contrast-related plan								
Supplements / herbals								

No single creatinine number, and no fixed number of days, makes every medicine safe to restart. Restart depends on: the original indication still applying, the acute trigger resolving, kidney function being stable enough, acceptable BP / volume / potassium, and monitoring in place. A small creatinine rise after restarting an ACEi/ARB is often expected, not a new injury; a rise over 30% needs review. "Over-the-counter" does not mean kidney-safe. **Do not restart or stop any prescription medicine without the agreed plan.**

ACEi = ACE inhibitor · ARB = angiotensin-receptor blocker · MRA = mineralocorticoid-receptor antagonist · SGLT2 = sodium-glucose cotransporter-2 · NSAID = non-steroidal anti-inflammatory drug. **Educational use only.**

Date	Weight (kg)	Sitting BP	Standing BP (if told)	Urine amount	Swelling	Breathless?	Vomiting / diarrhea / intake	Dizzy / faint	Glucose (if relevant)	Notes
Day 1										
Day 2										
Day 3										
Day 4										
Day 5										
Day 6										
Day 7										
Week 2										
Week 3										
Week 4										
Weekly…										

⚠ Fluids

Do not restrict or force fluids unless your clinician has given you a specific target. Fluid needs are individual — especially with heart failure, cirrhosis, or on dialysis, where too much fluid is harmful. If your dialysis access shows redness, swelling, or discharge, contact your team.

Symptoms that should trigger contact			
Medicines to pause temporarily when acutely ill *clinician-specified only*			
Maximum time to hold before contacting the team			
Medicines that must NOT be stopped without direct instruction			
Glucose / insulin instructions (if diabetic)			
Fluid advice & heart-failure exception			
Who to call			
During office hours		**After office hours / emergency**	
Date this plan should be reviewed		**Clinician signature**	

Seek urgent care now if you have any of these

Much less urine or no urine · new or worsening breathlessness, swelling, or rapid weight gain · unable to keep fluids down, persistent vomiting or diarrhea, or fainting · confusion, severe drowsiness, chest pain, severe weakness, or a racing/irregular heartbeat · fever, chills, or redness/discharge around a dialysis catheter · blood pressure or blood sugar your plan cannot control · any instruction from your team based on a dangerous potassium, bicarbonate, or creatinine result.

Contact your treating team or your local emergency service. Keep this planner and your medication list where a family member can find them.

Sick-day medicine guidance has low-certainty evidence and is easy to get wrong — it must be individualized, time-limited, and paired with a restart plan. Never blanket "stop everything."

Educational use only. This plan is written by your clinician for you specifically and does not apply to anyone else.

Status: AKI requiring dialysis — recovery under assessment

Dialysis after AKI is a treatment, not automatically a permanent diagnosis. About half of people who leave the hospital still on dialysis after AKI recover enough to stop, often within 90 days. Ask that your records say **"AKI-D — recovery under assessment,"** not "end-stage kidney disease," while recovery is still possible.

Dialysis unit & nephrologist			
Access type		**Current frequency / duration**	
Weekly recovery-monitoring (first month) — record the trend			
Predialysis SCr / BUN / K / HCO_3 trend			
Urine volume (24 h)		**Timed urine: date · duration · creatinine clearance**	
Pre / post weight & BP; intradialytic hypotension?		**Ultrafiltration target & symptoms**	
Diuretic plan			
Recovery-probability discussion date		**Trial-off-dialysis assessment date**	
Long-term access / modality discussion (if needed)			
Explicit status			
☐ AKI-D — recovery under assessment ☐ Recovery signals present — clinician assessment needed ☐ Preparing long-term KRT (recovery surveillance continues)			

No automated "safe to stop dialysis" output exists — and none belongs here. Predictors such as urine output > 450 mL/24 h without diuretics (or > 2,300 mL/24 h with diuretics) and a 2-hour timed creatinine clearance ≥ 23 mL/min may *help* predict successful discontinuation in adults, but they are predictors, not stop rules. A supervised trial off dialysis is a clinician decision that also weighs fluid balance, acid–base, electrolytes, catabolism, and the ability to rescue if the trial fails. Do not interpret diuretic-driven urine volume as recovered clearance. Confirm current PhilHealth eligibility and documentation with your treating facility.

Day-90 outcome — tick ONE

☐	Complete resolution by proposed draft criteria — history of AKI remains clinically relevant.
☐	Partial resolution — ongoing monitoring and risk-reduction plan required.
☐	New CKD identified.
☐	Pre-existing CKD worsened after AKI/AKD.
☐	Ongoing kidney failure / KRT — recovery assessment and long-term pathway documented.

Day-90 eGFR & UACR category		**Final / working diagnosis**	
Medication & kidney/heart-protection plan			
Recurrence-prevention & sick-day plan renewed?		**Next test & visit date**	
Nephrology follow-up?	☐ Yes ☐ No — why:	**Long-term surveillance interval**	

Patient teach-back — I can say in my own words

☐	I know my baseline kidney numbers.	☐	I know my warning signs.	☐	I know my medication plan and who owns it.

Clinician name		**Signature**		**Date**	

If no CKD is found

The right wording is **"no CKD identified at 90 days"** — not "your kidneys are permanently normal." A prior AKI stays a risk marker, so keep a plan for long-term surveillance and for the next time you get sick.

For educational use only. This planner incorporates proposals from the March 2026 KDIGO AKI/AKD public-review draft, which is not final and may change. It does not replace individualized medical advice. References & the full guide: renalcarematters.com/guides/aki-does-not-end-at-discharge.html