Penn Medicine | Penn Home Infusion Therapy

Date: _____

Time In: _____ Time Out: _____

Team: _____

VISIT REPORT SUMMARY

Patient Name: _____ Date of Birth: _____

Vital Signs BP: _____ HR: _____ RR: _____ TEMP: _____ WT (lbs.) _____

General

Reason for Visit: _____

Neurological

Level of Consciousness: ☐ Alert ☐ Oriented ☐ Disoriented ☐ Confused ☐ Lethargic ☐ Unable to Follow Commands ☐ Delayed Responses ☐ Limited Ability to Track Conversations ☐ Unresponsive

Neurological Abnormalities (if applicable): ☐ Headaches ☐ Numbness ☐ Tingling ☐ Dizziness ☐ Cold ☐ Sensitivity ☐ Spasticity ☐ Slurred Speech ☐ Seizures

Additional Comments: _____

Head, Eyes, Ears, Nose, Throat

Visual Changes? ☐ Yes ☐ No

Comments Regarding Vision: _____

Hearing Changes? ☐ Yes ☐ No

Comments Regarding Hearing: _____

Drainage (if applicable): ☐ Eyes ☐ Ears ☐ Nose

If drainage, describe (site, location): _____

Additional Comments: _____

Cardiac

Heart Sounds: ☐ WNL ☐ Abnormal

If abnormal heart sounds, describe: _____

Rhythm: ☐ Regular ☐ Irregular

Cardiac Devices: ☐ Holter Monitor ☐ Internal Defibrillator ☐ LifeVest ☐ LVAD ☐ Pacemaker

Cardiac Abnormalities: ☐ Angina ☐ Diaphoresis ☐ Edema ☐ Lightheadedness ☐ Murmur ☐ Neck Vein Distention ☐ Palpitations

If edema present, document location and scale: _____

Abdominal Girth (if applicable): _____

Orthostatic Blood Pressure (if applicable): _____

Additional Comments: _____

Respiratory

Breath Sounds: ☐ Clear ☐ Decreased ☐ Rhonchi ☐ Rales ☐ Wheezes

Breath Sound Comments: _____

Respiratory Symptoms (if applicable): ☐ Shortness of Breath ☐ Dyspnea at Rest ☐ Dyspnea on Exertion ☐ Orthopnea

Cough (if applicable): ☐ Nonproductive Cough ☐ Productive Cough

OXYGEN IN THE HOME? ☐ Yes ☐ No

If patient is using oxygen, document liter, frequency and duration: _____

If oxygen present, is there smoking in the home? ☐ Yes ☐ No

If oxygen present and smoking in the home, document communication: _____

If oxygen present, are there other fire safety risks in the home such as the potential for open flames (candles, cigarettes, fireplaces, gas range, lighters, matches, wood stoves, etc.)? ☐ Yes ☐ No

If oxygen present, are there functioning smoke detectors in the home? ☐ Yes ☐ No

Additional Comments: _____

Gastrointestinal

Bowel Sounds: ☐ WNL ☐ Hyperactive ☐ Hypoactive ☐ Absent

Abdomen: ☐ Soft ☐ Firm ☐ Distended ☐ Nontender ☐ Tender

If abdomen tender, describe location: _____

GI Symptoms (if applicable): ☐ Nausea ☐ Vomiting ☐ Dry Heaving ☐ Diarrhea ☐ Constipation ☐ Incontinence ☐ Cramping ☐ Bloating ☐ Mucositis ☐ Thrush ☐ Dysphagia ☐ Heart Burn/Indigestion

Feeding Tube/Usage/Details (if applicable): _____

Last BM: _____

Bowel Regimen (if applicable): _____

Ostomy (if applicable): _____

Additional Comments: _____

Nutrition

Weight Gain/Loss? ☐ Yes ☐ No

If weight gain/loss, document (lbs): _____

Diet: ☐ Regular ☐ Cardiac ☐ Diabetic ☐ Neutropenic ☐ Clear Liquids ☐ Full Liquids ☐ NPO ☐ Other: _____

Nutritional Supplements (if applicable): ☐ TPN ☐ Enteral ☐ Other

If other supplements, describe: _____

Appetite: ☐ Good ☐ Fair ☐ Poor ☐ Improved ☐ Worsening

Fluid Intake: ☐ Good ☐ Fair ☐ Poor ☐ Fluid Restriction

If fluid intake is poor or restricted, explain: _____

Blood Glucose Result (if applicable): _____

Additional Comments: _____

Genitourinary

☐ WNL ☐ Frequency ☐ Urgency ☐ Pain ☐ Burning ☐ Oliguria ☐ Anuria ☐ Hematuria ☐ Retention ☐ Incontinence ☐ Foley ☐ Straight Cath

Urine Color/Odor: _____

Additional Comments: _____

Musculoskeletal

Musculoskeletal Assessment: ☐ WNL ☐ Weakness ☐ Fatigue

If impaired range of motion, describe: _____

Mobility: ☐ Steady Gait ☐ Unsteady Gait ☐ Poor Balance ☐ Poor Endurance ☐ Ambulate with Assistance ☐ Assistive Device

Assistive Devices/Safety Devices (if applicable): ☐ Cane ☐ Chair Lift ☐ Crutches ☐ Commode ☐ Hospital Bed ☐ Knee Walker ☐ Prosthesis ☐ Shower Chair ☐ Walker ☐ Wheelchair ☐ Other: _____

Physical and/or Occupational Therapy Involved? ☐ Yes ☐ No

Fall Since Last PHIT Visits? ☐ Yes ☐ No

Description of Fall Including Date of Fall, Injury (if Sustained) and Name of Physician Notified: _____

Assistive Device in Use at Time of Fall? ☐ Yes ☐ No

Additional Comments: _____

Integument

Color: ☐ WNL ☐ Cyanotic ☐ Flushed ☐ Jaundice ☐ Mottled ☐ Pallor

Skin: ☐ Warm ☐ Dry ☐ Cool ☐ Moist

Turgor: ☐ Good ☐ Fair ☐ Poor

Integrity: ☐ Intact ☐ Bruises ☐ Erythema ☐ Rashes ☐ Abrasions ☐ Lacerations ☐ Wounds: Surgical ☐ Wounds: Non-surgical ☐ Other: _____

DO NOT USE UNAPPROVED ABBREVIATIONS

WHITE – PATIENT YELLOW – HOME CHART

Patient Name: _____ Date of Birth: _____

Integument *(continued)*

Locations: _____
Wound Care: ☐ Covered by Dressing ☐ Open to Air ☐ Sutures ☐ Staples ☐ Steristrips ☐ Drain ☐ Wound Vac
Home Care Agency Involved in Wound Management (name if applicable): _____
Additional Comment: _____

Psychosocial

☐ WNL ☐ Agitated ☐ Angry ☐ Anxious ☐ Combative ☐ Depressed ☐ Difficulty Coping ☐ Flat Affect ☐ Hallucinating ☐ Inappropriate ☐ Mood Swings ☐ Needs Encouragement ☐ Paranoia ☐ Sleep Disturbances ☐ Tearful ☐ Withdrawn ☐ Other: _____
Abnormal Sleep Patterns (if applicable): ☐ Trouble Falling Asleep ☐ Unusual Sleep Pattern
Primary Caregiver: _____
Support System Adequate: ☐ Yes ☐ No
Additional Comments: _____

Pain

Does the patient have pain? ☐ Denies ☐ Present
Location of Pain: _____
Quality of Pain: ☐ Aching ☐ Burning ☐ Cramping ☐ Dull ☐ Sharp ☐ Spasms ☐ Stabbing ☐ Throbbing ☐ Other: _____
Intensity at Present (0-10 scale): _____
Best Pain Rating in Last 24 Hours (0-10 scale): _____
Worst Pain Rating in Last 24 Hours (0-10 scale): _____
Acceptable Level of Pain (0-10 scale): _____
Duration of Pain: _____
Frequency of Pain: ☐ Constant ☐ Frequent ☐ Infrequent ☐ Intermittent ☐ Unknown ☐ With Activity
Pain Exacerbates With? _____
Relieving Factors: ☐ Medication(s) - See Medication Profile ☐ Cold ☐ Heat ☐ Exercise ☐ Eating ☐ Massage ☐ Relaxation ☐ Rest ☐ Repositioning ☐ Other: _____

IF PCA USED FOR PAIN:
Reservoir Volume: _____ **Concentration:** _____
Continuous Rate: _____ **PCA/Demand Dose:** _____
PCA/Demand Dose Lockout: _____ **Max Doses Per Hour:** _____
Doses Given: _____ **Doses Attempted:** _____
Date of Last Cassette/Bag Change: _____
PCA Lock Level: _____
If Pump Taken Out of Lock Level/Settings Changed, Document Reason and Name of Clinician Contacted for Second Person Verification: _____
Additional Comments: _____

Venous Access Assessment

Type of Access: ☐ No Access ☐ Peripheral ☐ Midline ☐ PICC ☐ Small Bore ☐ Hickman ☐ Apheresis ☐ Implanted Port ☐ Other: _____
Lumens: ☐ One ☐ Two ☐ Three **Size/Gauge:** _____
Venous Access Location: _____
Performance: ☐ All Lumens Flushing with Ease ☐ All Lumens with Positive Blood Return ☐ One or More Lumens Sluggish ☐ One or More Lumens Occluded ☐ One or More Lumens with No Blood Return
Describe Abnormal Performance and Lumen (if applicable): _____
Securement: ☐ Sutured ☐ StatLock ☐ Steri-Strip ☐ Other: _____
Site Assessment: ☐ Unremarkable ☐ Active Bleeding ☐ Blisters ☐ Dried Blood ☐ Drainage ☐ Foul Smelling ☐ Rash ☐ Redness ☐ Skin Tear ☐ Swollen ☐ Tender ☐ Warm-To-Touch ☐ Other: _____

Venous Access Assessment *(continued)*

PICC/Midline Arm Circumference (cm): _____
External Catheter Length (cm): _____
If changes in PICC site assessment or measurements, document communication: _____
Additional Comments: _____

Treatments

ACCESS MANAGEMENT: ☐ Peripheral Line Insertion ☐ Midline Insertion ☐ Ultrasound Utilized ☐ Port Access ☐ Port Deaccess ☐ PICC Line Removal ☐ Midline Removal ☐ Peripheral Line Removal
Identify Site/Vein Utilized for Line Insertion: _____
Identify gauge/length for line insertion or port access: _____
Number of attempts for line insertion or port access: _____
For Midline Insertion, document external length (cm): _____
For Midline Insertion, document arm circumference (cm): _____
For PICC/Midline removal, document total length (cm): _____

SITE CARE PROCEDURE(S): ☐ Dressing Change ☐ Extension Set Change ☐ Injection Cap Change ☐ Other: _____
Type of Cleansing: ☐ Chlorhexidine ☐ Alcohol ☐ Betadine ☐ Other: _____
Type of Securement: ☐ Line Sutured ☐ StatLock Placed ☐ Steri-Strips Placed ☐ Other: _____
Type of Dressing: ☐ Tegaderm CHG ☐ IV3000/Opsite ☐ Sorbaview ☐ Tegaderm ☐ Biopatch ☐ Primapore ☐ Gauze ☐ Other: _____

LABS OBTAINED: ☐ Peripheral Stick ☐ Central Line ☐ STAT
Time of Lab Draw: _____
Lab Tests: ☐ Amikacin Trough ☐ BMP ☐ CBC w/Diff and Platelets ☐ CMP ☐ CMV Quant ☐ CRP ☐ EBV Quant ☐ Iron/Transferrin ☐ LDH ☐ LFTs ☐ Magnesium ☐ NTproBNP ☐ Prealbumin ☐ Phosphorus ☐ PT/INR ☐ Sedimentation Rate (ESR) ☐ Tacrolimus ☐ Triglycerides ☐ Uric Acid ☐ Vancomycin Trough ☐ Blood Cultures - Central Line ☐ Blood Cultures - Peripheral
If other labs, describe: _____
If peripheral blood cultures obtained, document site(s): _____
Last Medication Dose Time (if applicable for timed dosing): _____
Lab Tracking Number: _____

AROMATHERAPY UTILIZED:
Type of Aromatherapy Utilized: _____
Reason(s)/Symptom(s) for Aromatherapy: _____
Symptom Scale (0-10) Prior to Aromatherapy: _____
Symptom Scale (0-10) Post Aromatherapy: _____
Additional Comments: _____

Pump Settings/Verification (Document PCA Settings in Pain Section)

PUMP #1:
Pump Type (if applicable): _____
Delivery Mode: ☐ Continuous ☐ Intermittent ☐ Step ☐ TPN/Taper
Pump Settings Verified Per Order and Medication Label ☐ Yes ☐ No
Document Pump Settings Below: _____
If Pump Taken Out of Lock Level or Settings Changed, Document Reason and Name of Clinician Contacted for Second Person Verification: _____
Chemotherapy Pump Res Vol (mL) Reset (if applicable)? ☐ Yes ☐ No

Patient Name: _____ Date of Birth: _____

Pump Settings/Verification (Document PCA Settings in Pain Section, *con't*)

PUMP #2:
Pump Type (if applicable): _____
Delivery Mode: ☐ Continuous ☐ Intermittent ☐ Step ☐ TPN/Taper
Pump Settings Verified Per Order and Medication Label ☐ Yes ☐ No
Document Pump Settings Below: _____

_____

_____

If Pump Taken Out of Lock Level or Settings Changed, Document Reason and Name of Clinician Contacted for Second Person Verification: _____

_____

_____

Additional Comments: _____

_____

Medication Administration

MEDICATION(S) ADMINISTERED DURING THIS VISIT (Name, Dose, Route, Rate/Time): _____

_____

_____

Document Vital Signs and/or Medication Titration Rates if Required for this Medication: _____

_____

_____

Line Flushed with: ☐ Saline ☐ Heparin ☐ Other: _____
Chemotherapy Hook-Up Time (if applicable): _____
If Anaphylaxis Kit Present, Document "Use By" Date: _____

ALTEPLASE (Cathflo) ADMINISTERED:
Document Lumen(s) for Alteplase: _____
Reason(s) for Alteplase Administration: ☐ Occlusion ☐ Sluggish ☐ No Blood Return
Outcome of Alteplase Administration: _____

Infection and Sepsis Screening

DOES THE PATIENT REPORT ANY OF THE FOLLOWING SYMPTOMS?
☐ Fever ☐ Chills and/or Sweats ☐ Change in Cough or a New Cough ☐ Sore Throat or New Mouth Sore ☐ Shortness of Breath ☐ Stiff Neck ☐ Burning or Pain with Urination ☐ Unusual Vaginal or Penile Discharge or Irritation ☐ Increased Urination ☐ Redness, Soreness, or Swelling in Any Area Including Surgical Wounds and Ports/Drains/IV Sites ☐ Diarrhea ☐ Vomiting ☐ Pain in the Abdomen or Rectum ☐ New Onset of Pain ☐ Pale or Discolored Skin ☐ Confused ☐ Sleepy or Difficult to Arouse
ARE ANY OF THE ABOVE INFECTION RELATED SYMPTOMS NEW SINCE THE LAST PHIT VISIT? ☐ Yes ☐ No
ARE ANY OF THE FOLLOWING SYSTEMIC CRITERIA PRESENT?
☐ Temperature Greater than 100.4F or Less than 96.8F ☐ Heart Rate Greater than 90 Beats/Minute ☐ Respiratory Rate Greater than 20 Breaths/Minute
DOES THE PATIENT MEET SIRS CRITERIA (2 OR MORE POSITIVE SYSTEMIC CRITERIA)? ☐ Yes ☐ No
IF PATIENT IS POSITIVE FOR SIRS CRITERIA, ARE ANY OF THE FOLLOWING NEW SIGNS OF ORGAN DYSFUNCTION PRESENT AT THIS VISIT? ☐ Altered or Change in Mental Status ☐ Sleepy or Difficult to Arouse ☐ Hypotension (Systolic BP Less than 90 or Decrease of Greater than 40 mm HG) ☐ Pale/Discolored ☐ Decreased Capillary Filling ☐ Decrease in Urine Output from Baseline with Adequate Fluid Intake ☐ Extreme Pain ("Worst Ever") or Generalized Discomfort
IF ANY SYMPTOM OF ORGAN DYSFUNCTION PRESENT, IMMEDIATE MEDICAL ATTENTION IS REQUIRED. DOCUMENT ACTIONS TAKEN:

_____

_____

Actions/Communication Based Upon Results of Infection and Sepsis Screening:

_____

_____

_____

_____

MAHC 10 - Fall Risk Assessment Tool

AGE 65+ ☐ Yes (Score 1) ☐ No
DIAGNOSIS (3 or more co-existing): ☐ Yes (Score 1) ☐ No
Includes only documented medical diagnosis
PRIOR HISTORY OF FALLS WITHIN 3 MONTHS: ☐ Yes (Score 1) ☐ No
An unintentional change in position resulting in coming to rest on the ground or at a lower lever.
INCONTINENCE: ☐ Yes (Score 1) ☐ No
Inability to make it to the bathroom or commode in timely manner. Includes frequency, urgency, and/or nocturia.
VISUAL IMPAIRMENT: ☐ Yes (Score 1) ☐ No
May include macular degeneration, diabetic retinopathies, visual field loss, age related changes, decline in visual acuity, depth perception, night vision, not wearing prescribed glasses or not having the correct prescription.
ENVIRONMENTAL HAZARDS: ☐ Yes (Score 1) ☐ No
May include but not limited to, poor illumination, equipment tubing, inappropriate footwear, pets, hard to reach items, floor surfaces that are uneven or cluttered, or outdoor entry and exits.
IMPAIRED FUNCTIONAL MOBILITY: ☐ Yes (Score 1) ☐ No
May include patients who need help with IADLS or ADLS or have gait or transfer problems, arthritis, pain, fear of falling, foot problems, impaired sensation, impaired coordination or improper use of assistive devices.
POLY PHARMACY (4 or more prescriptions - any type): ☐ Yes (Score 1) ☐ No
All PRESCRIPTIONS including prescriptions for OTC meds.
PAIN AFFECTING LEVEL OF FUNCTION: ☐ Yes (Score 1) ☐ No
Pain often affects an individual's desire or ability to move or pain can be a factor in depression or compliance with safety recommendations.
COGNITIVE IMPAIRMENT: ☐ Yes (Score 1) ☐ No
Could include patients with dementia, Alzheimer's, stroke patients or patients who are confused, use poor judgment, have decreased comprehension, impulsivity, memory deficits. Consider patients ability to adhere to plan of care.
MAHC 10 - FALL RISK ASSESSMENT SCORE:
Add all the scores next to "Yes" answers. A score of 4 or more is considered at risk for falling. ☐ Total Score: 0-3 ☐ Total Score: 4 or greater = FALL RISK

Teaching

PHIT INFORMATION: ☐ Review of PHIT 24 Hour Phone Number ☐ When to Contact PHIT/Physician ☐ Biohazard Waste Disposal/Pick Up Process ☐ Communication for Supply Needs
Additional PHIT Information Provided: _____

_____

CATHETER CARE AND COMPLICATION(S) TEACHING: ☐ Flushing Procedure ☐ Showering/Bathing ☐ Checking Integrity of Dressing ☐ Signs/Symptoms of Catheter Complications ☐ Post PICC Removal Instructions (Removal of Dressing in 24 hours, Cover Site with Bandage post dressing removal and Contact Physician with any Signs/Symptoms of Infection)
Additional Catheter Care and Complication Teaching: _____

_____

PHIT MEDICATION TEACHING: ☐ Medication Indication and Side Effects Reviewed ☐ Medication Storage Reviewed ☐ Flushing Procedure Reviewed ☐ Medication Route and Frequency Reviewed ☐ What to Do if Adverse Drug Reaction Develops ☐ What to Do if Dose(s) Missed ☐ How to Change Medication Time(s)
Additional Medication Teaching Provided: _____

_____

MEDICATION ADMINISTRATION AND INFUSION EQUIPMENT TEACHING: ☐ Tubing/Cassette Changes Reviewed ☐ Flushing Procedure Reviewed ☐ Connecting and Disconnecting Procedure Reviewed ☐ Self Administration Procedure(s) for Injectable Reviewed ☐ Pump Setting Reviewed ☐ Pump Battery Changes ☐ Battery Pack Reviewed ☐ Pump Alarms/ Troubleshooting Reviewed ☐ Home Mix/Additive(s) Preparations Reviewed
Additional Medication Administration and Infusion Equipment Teaching Provided: _____

_____

Patient Name: _____ **Date of Birth:** _____

Teaching *(continued)*

IS THIS A SCHEDULED INFECTION PREVENTION TEACHING AND OBSERVATION VISIT? ☐ Yes ☐ No

INFECTION PREVENTION TEACHING: ☐ Utilization of Clean Work Area ☐ Hand Hygiene ☐ Alcohol Swabbing Prior to Each Connection ☐ Aseptic Technique ☐ Monitoring Temperature ☐ Signs and Symptoms of Infection: Temp100.4 or greater, Sweating, Chills (whole body or during flusing/infusing), Pain/Redness/Swelling/Oozing at IV Site ☐ Observation of All Infection Prevention Teaching Completed at this Visit

If infection prevention teaching and observation visit, document observations requiring intervention or patient/caregiver feedback: _____

Additional Infection Prevention Teaching Provided: _____

HYDRATION AND NUTRITION TEACHING: ☐ Appropriate Daily Fluid Intake ☐ Signs/Symptoms of Dehydration ☐ Prescribed Diet Instruction ☐ Encouraged Small More Frequent Meals ☐ Discussed Nutritional Supplement Options

Additional Hydration and Nutrition Teaching Provided: _____

PAIN MANAGEMENT TEACHING: ☐ Bowel Regime due to Narcotics Reviewed ☐ Reviewed Non-Pharmacologic Strategies ☐ Reviewed Pain Medications Including Purpose, Side Effects and Administration Schedule

Additional Pain Management Teaching Provided: _____

CARDIAC TEACHING: ☐ Reviewed Weight Gain, BP Parameters and other Sign/Symptoms for Contacting Provider, ☐ Reviewed Adherence to Cardiac Diet ☐ Fluid Restriction Reviewed ☐ Reviewed Importance of Daily Weight and BP Checks ☐ For Patient Receiving Inotropic Medications: Reviewed Back-Up Pump Use

Additional Cardiac Teaching Provided: _____

DIABETIC TEACHING: ☐ Reviewed Diabetic Foot Care ☐ Reviewed Self Management of Diabetes (Blood Glucose Monitoring, Disease Process, Signs/Symptoms to Report and Interventions for Hypo/Hyperglycemia) ☐ Reviewed Diabetic Diet ☐ Reviewed Insulin Management ☐ Reviewed When to Contact Physician

Additional Diabetic Teaching Provided: _____

FALL PRECAUTION TEACHING:

Incontinence: ☐ Limit Fluid Intake 2-3 Hours before Bedtime ☐ Use of Commode ☐ Use of Protective Undergarments/Liners ☐ Path to Bathroom is Well Lit and Unobstructed ☐ Installation/Use of Grab Bars in Bathroom

Visual Impairment: ☐ Keep Areas Free of Clutter ☐ Assure Adequate Lighting ☐ Keep Glasses within Reach at All Times ☐ Recommend Vision Evaluation Appointment

Impaired Functional Mobility: ☐ Use of Appropriate Footwear ☐ Use of DME ☐ Slow Position Changes ☐ Safe Transfer Techniques ☐ Reinforce Risk Factors Related to Balance Deficit ☐ Discussed Potential Need for PT/OT

Environmental Hazards: ☐ Home Safety (Including: Cluttered Environment, Poor Lighting, Pets, IV/Oxygen Tubing, Throw Rugs, Cords, Stairs, Non-Slip Mats in Bathroom & Use of Railing/Grab Bars)

Poly Pharmacy: ☐ Side Effects of Medications that may Impair Cognitive Function, Cause Dizziness or Result in Hypotension ☐ Risks Associated with Drug Classes such as Antiarrythmics, Antihypertensives, Narcotics, Sedatives, Antipsychotics, Antianxiety, Antidepressants, Hypoglycemics

Pain Affecting Level of Function: ☐ Strategies for Non-Pharmacological Pain Management ☐ Notify Physician of Uncontrolled Pain or Ineffective Response to Pain Medication

Cognitive Impairment: ☐ Increased Monitoring, Easy Access to Assistive Devices and/or Supervised Ambulation ☐ Interventions Related to Impulsive Behavior (Redirection, Distraction and Increased Observation) ☐ Risks of Alcohol and/or Recreational Drug Use

Referral Made for PT/OT (List Name of Agency): _____

Additional Fall Precaution Teaching Provided: _____

Teaching *(continued)*

CHEMOTHERAPY PRECAUTIONS: ☐ Chemotherapy Disconnect/Leak Instructions ☐ Chemo Spill Kit ☐ Reviewed Checking Chemotherapy Tubing Connections ☐ Mouth Care/Oral Rinses ☐ Hydration and Antiemetics for Nausea ☐ Monitoring Temperature ☐ Use of Sunscreen ☐ Neutropenic Precautions ☐ Infection Precautions ☐ Sexuality Precautions ☐ Dietary Restrictions ☐ Reviewed Monitoring for Skin Changes

Additional Chemotherapy Precautions Teaching Provided: _____

OXYGEN PRECAUTIONS: ☐ Reviewed Safety Risks to Neighboring Residences/Buildings ☐ Reviewed Oxygen Provider Information ☐ Reviewed No Smoking in Home or Car while Oxygen in Use ☐ Reviewed Keeping Oxygen and Tubing at Least 10 Feet from Open Flames and Heat Sources ☐ Reviewed Avoiding Electrical Appliances with Oxygen Use ☐ Reviewed Importance of Posting Oxygen Signs ☐ Reviewed Avoidance of Petroleum or Oil Based Products on Face/Upper Chest ☐ Reviewed Fall Risks Related to Oxygen Tubing ☐ Reviewed Storage of Oxygen Tanks in a Rack or Laying Down on the Floor, Avoiding Closed Spaces ☐ Reviewed the Importance of Functioning Smoke Detectors and Checking Monthly

Additional Oxygen Teaching Provided: _____

ANTICOAGULATION PRECAUTIONS: ☐ Risk for Bleeding and Safety Precautions Reviewed ☐ Contact Physician with Falls and/or Signs/Symptoms of Bleeding ☐ Reviewed Dietary Concerns/ Limiting Vitamin K Intake ☐ Reviewed OTC Medication Restrictions

Additional Anticoagulation Teaching Provided: _____

GENERAL TEACHING: ☐ Reviewed Energy Conservation Related to Fatigue ☐ Reviewed Information Specific to Diagnosis and/or Comorbidities (Describe Below)

If other teaching provided, please describe:

Teach Back: Patient/caregiver verbalizes understanding of the teaching provided at this visit? ☐ Yes ☐ No

If No, further explain and/or document communication: _____

Additional Comments: _____

Medication Changes

Medication Changes? ☐ None ☐ Yes - (Dose, Rate, Frequency, Start, Stop)

Coordination of Care

Supply Needs: ☐ None ☐ Supply Needs Communicated Via Phone Call

List other agencies/organizations involved in this patient's care: _____

List other medical equipment in the home: _____

Care Plan Update

Care Plan Reviewed: ☐ Yes ☐ No

Care Plan Modification(s): ☐ N/A ☐ New Problem / Goal / Intervention ☐ Resolved Problem / Goal / Intervention

If care plan modification(s), describe: _____

Comments

Additional Comments: _____

Nurse's Signature _____ Print Name _____ Date _____ Time _____

WHITE – PATIENT **YELLOW – HOME CHART**