Patient Name: _____ Date of Birth: _____

Cardiac:

Heart Sounds: ☐ WNL ☐ Abnormal: _____
Rhythm: ☐ Regular ☐ Irregular
Cardiac Symptoms: ☐ Angina ☐ Palpitations
☐ Edema (1-4)/Location: _____
☐ Measurements If Applicable:
Abdomen: _____ cm.
Left ankle: _____ cm.
Right ankle: _____ cm.
Left calf: _____ cm.
Right calf: _____ cm.
☐ Diaphoresis ☐ Fluid Restriction
☐ Neck Vein Distention ☐ R ☐ L
☐ Lightheadedness ☐ Pacemaker Settings: _____ ☐ AICD
Comments: _____

Eyes, Ears, Nose, Throat:

☐ WNL ☐ Glasses ☐ Contacts ☐ Legally Blind
☐ Other: _____
☐ Visual Changes/Impairments: _____
☐ HOH: ☐ Loss of Hearing Left or Right ☐ Hearing Aids
☐ Alterations in Smell ☐ Dentures ☐ Throat Complications

Gastrointestinal:

Bowel sounds: ☐ WNL ☐ None ☐ Hypo ☐ Hyper
Abdomen: ☐ Soft ☐ Firm ☐ Distended ☐ Tender
GI Symptoms: ☐ Nausea ☐ Vomiting ☐ Diarrhea
☐ Constipation ☐ Incontinence
☐ Tube Feeding Tube Type: _____
☐ Tube Feeding Brand: _____
Last BM: _____
☐ Ostomy: _____
Comment: _____

Genitourinary:

☐ WNL ☐ Frequency ☐ Urgency ☐ Pain ☐ Burning ☐ Oliguria
☐ Anuria ☐ Hematuria ☐ Retention ☐ Incontinence
☐ Foley ☐ Straight Catheter ☐ Urostomy
☐ Penile/Vaginal Discharge Color/Odor: _____
Pregnant? Yes No
Output: _____ ml. LMP _____ ☐ N/A
Comments: _____

Integument:

Color: ☐ WNL ☐ Jaundice ☐ Cyanotic ☐ Pallor ☐ Flushed
Skin: ☐ Warm ☐ Dry ☐ Cool ☐ Moist
Turgor: ☐ Good ☐ Fair ☐ Poor
Integrity: ☐ Intact ☐ Bruises ☐ Erythema ☐ Rashes
☐ Abrasions ☐ Other: _____
☐ Lacerations ☐ Wounds: Surgical Non-surgical
Location/Description/Drainage: _____
Comment: _____

Neurological:

☐ Alert ☐ Oriented ☐ Disoriented ☐ Confused ☐ Lethargic
☐ Numbness ☐ Tingling ☐ Tremors ☐ Dizziness ☐ Seizures
☐ Spasticity ☐ Headaches, Locations: _____
Comments: _____
Communication: _____
☐ Aphasia ☐ Expressive ☐ Receptive ☐ Unresponsive
☐ Slurred Speech ☐ Other: _____

Nutrition:

Diet: ☐ Regular ☐ Cardiac ☐ Diabetic: _____ ☐ Neutropenic
☐ Soft ☐ Clear Liquids ☐ Full Liquids ☐ NPO ☐ TPN
☐ Enteral ☐ Other: _____
☐ Supplements: _____
Appetite: ☐ Good ☐ Fair ☐ Poor ☐ N/A
☐ Improved ☐ Worsening
Fluid Intake: ☐ Good ☐ Fair ☐ Poor ☐ N/A
☐ Fluid Restriction: _____ mL/per day: _____

Pain:

Pain Present: Yes No
Location: _____
Type/Quality: ☐ Chronic ☐ Acute ☐ Aching ☐ Burning ☐ Dull
☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Other: _____
Intensity (1-10) _____ Duration: _____
Pain Exacerbates with: _____
Pain Medications: _____
Other Relief Measures: _____
Comments: _____
☐ See Comprehensive Pain Assessment Page

Psychosocial:

☐ WNL ☐ Anxious ☐ Depressed ☐ Agitated
☐ Crying ☐ Withdrawn ☐ Inappropriate
☐ Needs Encouragement
Primary Caregiver: _____
Support System Adequate: Yes No
Comments: _____
Plan of Care Reviewed: Yes No
Care Plan Modified: Yes No
Comments: _____

Respiratory:

Breath sounds: ☐ Clear ☐ Decreased ☐ Rhonchi
☐ Rales ☐ Wheezes Location: _____
Respiratory: ☐ SOB ☐ Dyspnea at Rest
☐ Dyspnea on Exertion ☐ Orthopnea
Cough: ☐ Productive ☐ Nonproductive ☐ Sputum
Color: _____
Oxygen in the Home: Yes No Liters: _____
Sleep Apnea: Yes No ☐ CPAP ☐ BiPAP
Comments: _____

Musculoskeletal:

☐ WNL ☐ Weakness ☐ Pain ☐ Fatigue
Impaired Range of Motion: Yes No
Location: _____
Mobility: ☐ Steady Gait ☐ Unsteady Gait ☐ Poor Balance
☐ Poor Endurance ☐ Ambulate with Assistance
Assistive Device: ☐ Cane ☐ Crutches ☐ Walker
☐ Wheelchair ☐ Splints

DME Equipment in Use: _____
DME Company: _____
Company Phone #: _____
☐ Specify Activity Limitations: _____
Falls: Yes No
Physical Therapy: Yes No
Comments: _____

WHITE - NBN INFUSIONS YELLOW - OTHER

Patient Name: _____ Date of Birth: _____

Venous Access Assessment:

Type of Access: ☐ No Access ☐ PIV ☐ Midline ☐ PICC ☐ Hickman ☐ Pheresis ☐ Dialysis ☐ Central Line Catheter
☐ Implanted Port ☐ SQ ☐ Other: _____
Lumens: _____ Location: _____ Size/Gauge: _____
☐ Clean/Dry ☐ Intact ☐ Edema ☐ Drainage Phlebitis: ____(0-4) ☐ Redness Comment: _____
PICC/Midline Measurements: Arm Circumference: _____cm. External Catheter Length: _____cm.(From insertion site to end of "y")
Total Length of Catheter Removed: _____cm. (if applicable) ☐ Tip Intact
Comments: _____

Medications:

Medications Administered (route, dose time): _____
☐ *(See NBN Infusion Record for Patient Data)* _____

Site Care:

Dressing: ☐ Changed ☐ Sterile ☐ Transparent ☐ Primapore ☐ Sorbaview ☐ Gauze ☐ Compression Dressing _____
☐ Biopatch Changed ☐ Statlock Changed ☐ Injection Cap/s Changed ☐ Extension Sets Changed ☐ Other: _____
☐ Lines Flushed: ☐ Sterile Saline _____ml. ☐ Heparin: _____units/_____ml. ☐ D5W: _____ml.
☐ PIV D/C Post Med. Admin. Pressure, Gauze and Tape Applied. Free of infiltrate or infection.
Performance: ☐ Flushing with Ease ☐ Sluggish ☐ Occluded ☐ Positive Blood Return
☐ No Blood Return ☐ Other: _____
Securement: ☐ Stat Lock ☐ Sutures ☐ Steri-Strips ☐ Sterile Tape ☐ Other: _____
Treatments: ☐ Inserted ☐ Removed ☐ Site Rotated Date Inserted: _____ Number of Attempts: _____(No more than 3)
☐ PIV ☐ Midline/Huber Lot number: _____ Brand: _____
Gauge/Size: _____ Location: _____
Pump Verification: ☐ N/A Serial #: _____ Pump Type/Model: _____
Settings: ☐ Cont. ☐ Intermittent Res Vol: _____mls. Dose: _____ Period/Rate: _____
☐ Frequency: _____ ☐ KVO Rate: _____ Lock Level: _____
☐ Bolus Amount: _____ Freq. _____ ☐ Taper Up ☐ Taper Down ☐ Settings Verified
☐ Back up Pump for Emergency High Risk Use Serial #: _____

Labs Obtained:

Labs Obtained: Yes No ☐ Butterfly/Peripheral Stick ☐ Central Line ☐ Other Time Drawn: _____ ☐ STAT
Labs Drawn: _____ Blood Culture Location of Draw: _____
Last Dose of Medication for Timed Draw: _____ Lab Tracking Number: _____
Lab Dropped off to: _____ Time Dropped off: _____
Comment: _____ Labels:

Teaching:

Person Educated: ☐ Patient ☐ Caregiver ☐ Other: _____
☐ NBN Medication/Administration Teaching
☐ Infusion Equipment/Pump/Return Demo ☐ CathCare ☐ Inotrope Self Monitoring ☐ SQ Admin./Injection
Precautions: ☐ Anticoagulant ☐ Chemotherapy ☐ Neutropenia ☐ Oxygen ☐ Fall
☐ NBN 24 Hour Phone Number ☐ When To Contact 911/MD ☐ S/S of Infection ☐ S/S of Catheter Complications ☐ Med Storage
☐ Hand Washing/Aseptic Technique ☐ Diet/Nutrition ☐ Hydration/Fluid Restriction ☐ Post PICC/Midline/PIV Removal Care
Patient/Caregiver Verbalizes Understanding of the
Teaching Provided: Yes No
Supplies Reviewed: Yes No
See Inventory Requisition: Yes No
☐ Other Health Care Agencies Involved in Patients' Care/Medical supplies: _____
☐ Sharps Return (DO NOT THROW AWAY)

Nutritional Risk Screening:

☐ Patient has illness or condition that makes him/her change the kind and/or amount of food eaten	 2	☐ Does not always have enough money to buy the food needed	 4
☐ Eats fewer than 2 meals per day	 3	☐ Eats alone most of the time	 1
☐ Eats few fruits and vegetables or milk products	 2	☐ Takes 3 or more prescribed or over-the-counter drugs/day	 1
☐ Has 3 or more drinks of beer, liquor or wine almost everyday	 2	☐ Without wanting to, has lost or gained 10 lbs. in the last 6 months	 2
☐ Has tooth or mouth problems that make it hard for him/her to eat	 2	☐ Not always physically able to shop, cook, and/or feed themselves	 2

→ **TOTAL:** _____

☐ 0-2 Low Nutritional Risk ☐ 3-5 Moderate Nutritional Risk ☐ 6 or More High Nutritional Risk – Diet/Nutrition Teaching

WHITE - NBN INFUSIONS YELLOW - OTHER

NBN 200-13

Patient Name: _____ Date of Birth: _____

Fall Risk Screening:

History of Falls (High Risk)	..... Yes	No	Expresses Fear of Falling	..... Yes	No
Poor Conditioning/Endurance	..... Yes	No	Weakness	..... Yes	No
Poor Judgment	..... Yes	No	Neuromuscular Disorders	..... Yes	No
Impulsivity	..... Yes	No	Neuropathies	..... Yes	No
Shuffling Gait	..... Yes	No	Amputations	..... Yes	No
Wandering Behavior	..... Yes	No	Alcohol/Drug Abuse	..... Yes	No
Confusion/Agitation	..... Yes	No	Incontinence	..... Yes	No
Balance Deficit	..... Yes	No	New or Changed Dose of Medication such as		
Visual Deficit	..... Yes	No	Antihypertensive, Diuretics, CNS Depressants.	..... Yes	No
Perceptual Deficit	..... Yes	No	Environmental Hazards	..... Yes	No

IF "YES" TO HISTORY OF FALLS AND/OR "YES" TO 2 OR MORE INDICATORS, INSTRUCT PATIENT/CAREGIVER ON FALL PRECAUTIONS

COMMENTS/TREATMENTS PERFORMED (DESCRIBED): _____

PATIENT TEACHING REVIEWED WITH PATIENT/CAREGIVER ☐

ADDITIONAL TEACHINGS OR PROBLEMS: _____

ADDITIONAL COMMENTS:

RN SIGNATURE: _____ **DATE:** _____

NEXT SCHEDULED VISIT: _____

WHITE - NBN INFUSIONS YELLOW - OTHER

NBN 200-13

NBN Infusions

INFUSION RECORD

PATIENT NAME:_____ IV/SQ SITE:_____ DATE OF INFUSION:_____

DRUG/DOSE ADMINISTERED: _____ PATIENT WEIGHT: _____ KG / POUNDS (Circle)

PREMEDICATION _____ TIME ADMINISTERED_____

PREMEDICATION _____ TIME ADMINISTERED_____

PREMEDICATION _____ TIME ADMINISTERED_____

TIME INFUSION STARTED:_____ ML/HR _____

	PRE-INFUSION TIME:	15 MINUTES TIME:	30 MINUTES TIME:	45 MINUTES TIME:	1 HOUR TIME:	TIME:	TIME:	TIME:	TIME:	TIME:
Infusion RATE										
TEMPERATURE										
HEART RATE										
RESPIRATION										
BLOOD PRESSURE										
IV/SQ SITE CHECK										
RENAL STATUS URINE OUTPUT										
ADVERSE RXNS NOTED										
TOTAL AMOUNT INFUSED (ML)										

TOTAL AMOUNT INFUSED:_____ TIME INFUSION COMPLETED_____

NURSE SIGNATURE:_____ DATE:_____

PRINTED CLINICIAN NAME:_____ *NARRATIVES IN CLINICAL PROGRESS NOTES*

NBN Infusions
A DIVISION OF THE NBN GROUP

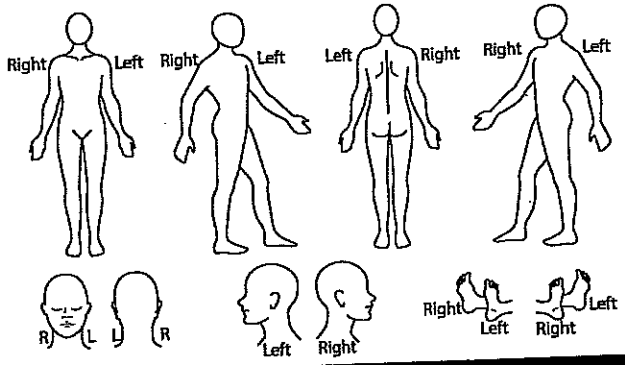
Date: _____
D.O.B.: _____

Pain Assessment

Patient's Name: _____ Diagnosis: _____
Etiology if known: _____ Physician: _____
If patient is cognitively impaired, name of person giving information: _____
Do you have (do you feel the patient is having) pain/discomfort now? _____
Presence of common or cultural beliefs that would inhibit reporting pain/discomfort? _____

1. LOCATION

Patient or nurse mark drawing. If more than one site, label A, B, C, D.



2. TYPE OF PAIN

- ☐ Aching
- ☐ Burning
- ☐ Cramping
- ☐ Deep Pressure
- ☐ Dull
- ☐ Electrical
- ☐ Neuralgia
- ☐ Diffuse
- ☐ Sharp
- ☐ Pulling
- ☐ Spasms
- ☐ Throbbing
- ☐ Stabbing
- ☐ Shooting
- ☐ Other _____

3. PHYSIOLOGICAL TYPE OF PAIN ASSESSED:

☐ **Somatic**
- Well localized in bone, blood vessels, subcutaneous tissues, muscle, and connective tissues
- Described as gnawing, aching, constant throbbing

☐ **Visceral**
- Poorly localized, diffuse in organs and lining of the body cavities
- Described as cramping, dull, constant, deep pressure

☐ **Neuropathic**
- Nerve injury pain due to the destruction of the nerve endings
- Described as a burning and shock-like sensation

4. DOCUMENT INTENSITY USING THE SCALES

Intensity at present: (As rated by patient/caregiver): Intensity scale:

Scale Used: ☐ FACES Scale ☐ 0 - 5 Rating
0-10 Numerical Rating: _____ Acceptable Level of Pain: _____
Worst Pain Gets: _____ Best Pain Gets: _____
☐ Patient unable to rate the pain. Who reports the pain?

5. ONSET:

- ☐ Sudden
- ☐ Gradual
- ☐ Chronic
- ☐ Continuous
- ☐ Intermittent
- ☐ Breakthrough
- ☐ Other
- ☐ Daily
- ☐ All The Time
- ☐ Sporadic
- ☐ At Night
- ☐ Occasionally

6. WHAT CAUSES OR INCREASES THE PAIN?

- ☐ Physical Activity
- ☐ Inactivity
- ☐ Sleeping
- ☐ Touch
- ☐ Body Positioning
- ☐ Other: _____

7. WHAT ALLEVIATES THE PAIN?

☐ Medication
Current Medication Management: _____

- ☐ Short Acting Medication
- ☐ Heat/Cold
- ☐ Body Repositioning/Exercise
- ☐ TENS Unit
- ☐ Physical Therapy
- ☐ Dimming of Light
- ☐ Nothing
- ☐ Long Acting Medication
- ☐ Relaxation/Breathing
- ☐ Massage
- ☐ Reduced Noise
- ☐ Music Therapy
- ☐ Rest
- ☐ Counseling
- ☐ Other: _____

8. WHAT EFFECT DOES THE PAIN HAVE ON A PERSON'S QUALITY OF LIFE?

PHYSICAL:
- ☐ Decreased functional ability
- ☐ Diminished strength, endurance
- ☐ Nausea, poor appetite
- ☐ Poor or interrupted sleep, no restorative sleep
- ☐ Excessive sleeping
- ☐ Constipation

SOCIAL:
- ☐ Diminished social relationships
- ☐ Decreased sexual functions, affection
- ☐ Altered appearance
- ☐ Increased caregiver burden
- ☐ Irritability

PSYCHOLOGICAL:
- ☐ Diminished leisure, enjoyment
- ☐ Increased anxiety, fear
- ☐ Depression, personal distress
- ☐ Difficulty concentrating
- ☐ Difficulty coping
- ☐ Anger
- ☐ Crying
- ☐ Withdrawal

SPIRITUAL:
- ☐ Increased suffering
- ☐ Altered meaning
- ☐ Reevaluation of spiritual beliefs

9. PAIN PLAN:

- ☐ Notify Physician
- ☐ Discuss with patient other modalities of management
  - ☐ Counseling
  - ☐ Stress Management
  - ☐ Exercise/Rehabilitation
  - ☐ Energy Conservation
  - ☐ Education
  - ☐ Bowel Regime

Financial resources to fill prescription(s): ☐ Yes ☐ No
☐ Referral made:
Patient satisfied with current plan of care of pain management?
☐ Yes ☐ No

RN Signature: _____

Royal Quality Nursing Services, Inc. **Plan of Treatment**

Patient: _____ **DOB:** _____ **SOC Date:** _____

Address:_____ **City:** _____ **State:** _____ **Zip:** _____

Provider_____

Diagnosis: Primary _____ ICD9 Code: _____

Secondary _____ ICD9 Code: _____

Code Status: Resuscitate DNR DNI Durable Power of Attorney

_____

Allergies: (List allergen and describe reaction.): _____

_____

Medication: _____

_____

_____

Flush Access Device: NSS ____ mL(s) □ before and after med administration □prn □____ mL(s) post lab draws

Heparin _____ units/mL _____mL(s) □ after med administration □ prn □ post lab draws

Other flush solution: _____

□See current medication profile attached. Physician to review and contact Royal Quality with any inconsistencies.

□See attached Acute Infusion Reaction Orders.

Maintain Catheter Access Type:

□N/A □ PICC □Intrathecal □Implanted port

□Peripherial □ Central tunneled □ Implanted pump □Subcutaneous infusion

□Midline □ Epidural □ Central non-tunneled □Other: _____

□If catheter is removed, may replace with: _____

□ May remove PIV at end of therapy □ Remove PIV after each infusion

□ Replace PIV: □ every 72-96 hours □ prn complications □ maximum of 7 days dwell time

Central Catheter/PICC repair by: □ Hospital □ Royal Quality Nurse □ N/A

□ May apply heat to treat and/or prevent access device complications

□ May apply antibiotic ointment after CVC removal

□ Reaccess port every ____ days or every ____ week(s) when not in use

□ May administer Alteplase 2mg IV prn occluded CVC, and repeat once if needed

Patient Name:_____

Dressing Change: □ Transparent every ____ days and prn □ Gauze every _____ days and prn

□ Other: _____

Teach patient/caregiver the following procedures: □ Catheter dressing change □ Medication administration

□ Access port □ Deaccess port □ Remove PIV Other: _____

Lab Orders: _____

□ Labs may be drawn from access device

□ Patient/caregiver may be taught how to draw labs from access device

Nursing Visit Frequency: □ Weekly and prn □ Other: _____

□ RN to administer prescribed therapy □ Home □ Hospital □ Nursing Home □ Other _____

Diet:
□ Regular □ Diabetic □ Renal □ Other diet restrictions: _____

Enteral Feedings: _____

Wound Care: _____

Other: _____

Goals:

□ Patient will complete therapy as prescribed, without complications.

Patient specific and measurable goals for this certification period include:

□ _____

□ _____

Discharge Plan: □ Unknown date □ Discharge from services on: _____

Certification Period: _____ to _____ □ Initial Certification □ Recertification

Clinician Signature: _____ **Date**: _____

I hereby certify that the above infusion and services are medically necessary and are authorized by me. The patient is under my care and is in need of the services listed. An infusion pump and all supplies may be provided as required for the administration of the above prescribed therapies.

Physician Name (Print) _____ **Physician's Address** _____

_____

Physician's Phone _____ **Physician's Fax** _____

Physician's Signature X_____ **NPI#** _____ **Date** _____

(Please complete and return within **24** hours of SOC.)

REV ACH 6/2014

NBN Infusions
A DIVISION OF THE NBN GROUP

NBN Teaching Care Plan

856. 669. 0217

Patient Name: _____

Date of Birth: _____

NBN Teaching Record	Date	Comment	Independent	Non-Independent
THERAPY:				
Principles of Therapy				
Treatment Requirements				
Patients Rights & Responsibilities				
Plan of Care				
Medication Information				
Side Effects				
Delivery Schedule				
SAFETY/INFECTION CONTROL:				
Hand Hygeine				
Clean Work Area Asepsis				
Standard Precautions				
Contact Precautions				
Respiratory Hygiene				
Waste Disposal				
Environmental Safety				
Spill/Chemo Precautions				
Fall Precautions				
Supplies/Equipment/Inventory				
Oxygen Requirements				
MEDICATIONS:				
Name of Patient/Drug Verified				
Storage/Inspection				
Additives				
Preparation				
Dosage/Concentration				
Expiration Date				
Room Temperature Stability				
Refrigerate Medication (if applicable)				
ADMINISTRATION:				
Pump: _____				
Alarms				
Back-up pump/Battery/Power pack				
PCA				
Catheter/Tube Placement				
Connection Procedures				
Disconnection Procedures				
Rate of Administration				
Flushing (Saline &/or Heparin)				
SASH Protocol				
Blood Back-up				
SELF – MONITORING:				
Weight				
Temperature				
Intake/Output				
Catheter Site S/S of Infection				
DME Alarms				
When to call 911/Doctor				
1-800-253-9111 Hour Emergency				
COMPLICATIONS:				
Infiltration/Extravasation				
Phlebitis (Chemical/Bacterial/Mechanical)				
Infection (Local/Bloodstream)				
Cellulitis				
Hematoma				
Venous Spasm				
Embolism (Air, Pulmonary, Catheter)				
Venous Thrombosis				
Speed Shock				
Pulmonary Edema				
Nerve Damage				
Device Allergic Reaction				
Catheter Migration/Malposition				
Catheter Occlusion/Fracture				
Cardiac Tamponade/Arrhythmias				
Absence of Blood Return				

1. RN Signature _____
2. RN Signature _____
3. RN Signature _____

I/we _____ have received educational material, and agree to undergo instruction to feel competent to safely and effectively perform the functions associated with the prescribed therapy. I/We understand that I/We will routinely perform these functions in a facility other then a hospital or medical institution.

Patient/Caregiver Signature _____ **Date** _____

WHITE - NBN INFUSIONS YELLOW - PATIENT

NBN 203- 13

NBN Infusions
A DIVISION OF THE NBN GROUP

Environmental Safety Assessment

Patient: _____ Equipment: _____

Completed in: ☐ Pt's home ☐ Hospital ☐ Office ☐ Other: _____

Driver's License #: _____ State: _____

Other ID Type #: _____ ID Not Available: ☐

1. Do any of the following safety concerns exist in the home? ☐ None

☐ Ungrounded outlets
☐ Lack of fire extinguisher
☐ Lack of smoke detectors
☐ Smokers
☐ Use of extension cords
☐ Loose/uneven floor or steps
☐ Narrow doorways
☐ Throw rugs
☐ Pests/dusty/dirty environment
☐ Inadequate equipment space
☐ Lack of refrigeration
☐ Other: _____
☐ Lack of electricity/water
☐ Frequent electrical outages
☐ No phone service

Action Taken: _____

2. Does the patient admit to any functional/psychosocial limitations that may affect care? ☐ None

☐ Poor Eyesight
☐ Unable to hear alarms
☐ History of stroke/CVA
☐ Weakness
☐ Arthritis
☐ Limited ambulation
☐ Uses ambulation/mobility aid
☐ Limited dexterity
☐ Limited communication
☐ Language barrier
☐ Shortness of breath
☐ Coughing/wheezing episodes
☐ History of falls
☐ Unaddressed pain
☐ Pertinent allergies/sensitivities: _____
☐ Dizziness or blackouts
☐ Difficulty rising or stooping
☐ Forgetful/disoriented

Other: _____

Action taken: _____

3. Does the patient have capable and willing caregiver support? ☐ Yes ☐ No ☐ None Needed

4. Other current services being provided?

(Other services should be notified of our involvement. Document on Communication/Telephone Log)

☐ Home Health Nursing/Home Health Aide/Hospice: _____
☐ Pharmacy Services: ☐ IV Therapy ☐ Enteral Therapy ☐ Other: _____
☐ Other Medical Equipment: _____ Provided By: _____

5. DME Plan of Care ☐ Not Applicable/ no equipment in use

Problems/Needs Identified	Goals	Actions/Interventions
1. Patient/caregivers have a knowledge deficit in operating and maintaining equipment listed.	1. Patient will demonstrate safe use, storage, and cleaning of equipment.	1. Patient was instructed on the safe use, cleaning, and storage of equipment per policy.

COMPLETE THIS SECTION FOR MANUAL WHEELCHAIR DELIVERY ONLY			
Pt agrees to utilize manual wheelchair?	Y / N	Wheelchair is able to be maneuvered between rooms?	Y / N
Pt agrees to use for daily mobility activities?	Y / N	Wheelchair is able to be maneuvered on surfaces?	Y / N
Patient able to self-propel?	Y / N	If No, caregiver present, willing, able to assist in propelling?	Y / N

☐ Patient /caregiver able and willing to learn needed skills, and patient/caregiver provided returned demonstration on a safe and proper use of equipment listed above

Comments: _____

Agency Representative: _____ Date: _____

FOR OFFICE ONLY

NBN Infusions
A DIVISION OF THE NBN GROUP

Medication Profile

DO NOT USE THESE DANGEROUS ABBREVIATIONS

Trailing Zeros	U or IU	Naked Decimal Points
q.d. or QD	MgSO4 MS or MSO4	q.o.d. or QOD

Patient's Name: _____ **Date:** _____ **DOB:** _____ **Phone#:** _____

Primary Diagnosis: _____

Allergies: _____

	START DATE	DRUG/THERAPY/CONCENTRATION	DOSAGE	ROUTE	FREQUENCY	PER PATIENT VERBALIZED USE	COMMENTS	STOP DATE
Prescription								
OTC								
Home Remedy								

WHITE - NBN INFUSIONS YELLOW - PHARMACY

RN SIGNATURE: _____

NBN 202- 13

NBN Infusions, Inc. **Authorization to Release Information** (Please Print)

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows the Healthcare Provider to release your protected health information to a person or organization that you choose.

Patient Information (individual whose information will be released)

Name: (First, Middle, Last, Title)	**Date of Birth:** (Month/Day/Year)
Address: (including zip code)	**Telephone Number:** (including area code)

Healthcare Provider: NBN Infusions, Inc.

I authorize NBN Infusions, Inc. to release my protected health information as described below.

Signature_____Date_____

Print Name_____

Recipient: (person or organization that will receive your information)

Person's Name or Organization:	**Telephone Number: (including area code)**
Address: (including zip code)	**Fax Number: (if available)**

Description of the Information to be Released: (what type of information will be released)

Check only one box:

☐ **Psychotherapy notes** – Federal law requires an authorization to use or release psychotherapy notes. If you check this box, **you may** not check another box below.

☐ **All information related to the provision of and payment for my health care.***

☐ **Specific information described below:***

_____

Purpose of Release

_____

Examples: At my request; To resolve a benefit payment appeal; To assist with my health insurance claim.

***NOTE:** The law requires that you give specific permission to release the information below even if you checked a box above. Indicate your permission for the Healthcare Provider to release any of the following information by initialing all that apply.

Genetic Information _____(Initials) **HIV/AIDS**_____(Initials)

Substance/Alcohol Abuse _____(Initials) **Mental/Behavioral Health** _____(Initials)

Expiration: (when this authorization will end)

This authorization will expire on __/__/__(mm/dd/yyyy) **OR** on the occurrence of the following event:

_____

Examples: Until I revoke this authorization; Resolution of a specific issue

Approval: (You OR your personal representative must sign and date this form in order for it to be complete)

I understand that this authorization to release information is voluntary and is not a condition of treatment. This authorization may be revoked at any time by sending a letter to us by fax, certified mail, hand delivery or overnight delivery service. Your revocation will be effective except to the extent that action has already been taken on the authorization or if it was obtained as a condition of obtaining insurance and a law provides the insurer the right to contest a claim under the policy. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the privacy regulations of federal and state law.

Patient Signature: By signing below, I authorize the use of my protected health information.	**Personal Representative Information:** A personal representative is a person who has the legal authority to act on behalf of an individual. A copy of a Power of Attorney or other court-issued legal document must be submitted with this Authorization.

_____ (Signature of Patient)

_____ (Date)

_____ (Printed Name of Representative)

_____ (Date)

_____ (Telephone Number)

_____ (Signature of Personal Representative)

_____ (Description of Representative's Authority)

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS **Revised 2-27-2017**