NBN Infusions
A DIVISION OF THE NBN GROUP

Patient Name: _____
Nurse Name: _____ Total Travel Time: _____
Total Hours: _____ To: _____ From: _____
Date: _____ Time In: _____ Time Out: _____
Nurse's Signature: _____

NBN Infusions, Inc. Visit Report

Patient Signature: _____ Date of Birth: _____

Vital Signs:

BP: _____ RR: _____
HR: _____ O2 Sats.: _____ (if applicable)
Temp.: _____ Blood Glucose: _____ (if applicable)
Weight kg.: _____ Gain/Loss: _____ Height: _____
Comment: _____

Cardiac:

Heart Sounds: ☐ WNL ☐ Abnormal: _____
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.
Comments: _____

Eyes, Ears, Nose, Throat:

Visual Changes: Yes No
Hearing Changes: Yes No
Drainage (Site, Location): _____
Comment: _____

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
Output: _____ ml. Color/Odor: _____
Comments: _____

Integument:

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

Musculoskeletal:

☐ WNL ☐ Weakness ☐ 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 Falls: Yes No
Physical Therapy: Yes No
Comments: _____

Neurological:

☐ Alert ☐ Oriented ☐ Disoriented ☐ Confused
☐ Lethargic ☐ Headaches ☐ Numbness ☐ Tingling
☐ Tremors ☐ Dizziness ☐ Seizures ☐ Spasticity
Comments: _____

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: _____

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: _____

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):_____ Medication Changes: yes ☐ no ☐ _____
☐ *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)

Additional Comments/Notes:_____

Nurses Signature:_____ **Date:** _____
Next Scheduled Visit: _____

WHITE - NBN INFUSIONS YELLOW - OTHER **NBN 209- 13**