NURSING VISIT SUMMARY

PATIENT NAME_____ PATIENT SIGNATURE_____ VISIT DATE___/___/____
TIME IN:_____am/pm TIME OUT:_____am/pm TOTAL TIME:_____HRS

Therapy: ☐ ABX ☐ TPN ☐ IVIG ☐ Steroids ☐ SCIG ☐ Other_____ Delivery via: ☐ Gravity ☐ Pump: ☐ CAAD ☐ BODYGUARD ☐ CURLIN ☐ OTHER	☐ Scheduled ☐ Unscheduled REASON FOR VISIT: ☐ Instruction ☐ Lab Draw ☐ Assessment ☐ IV re-start ☐ Line Care ☐ Port Access ☐ Medication Aadmin.	Vital signs: BP_____/_____ Pulse_____ RR_____ Temp_____ Weight_____

NEURO/PSYCH ☐ WDL: A&O x 3, speech spontaneous; denies anxiety, depression, headache, blurred vision, dizziness, tremors, numbness, tingling. ☐ WDL except deviations noted→	☐ lethargic ☐ sluggish ☐ confusion ☐ restlessness ☐ memory loss ☐difficulty concentrating ☐ Numbness ☐ Tingling ☐ Anxious ☐ Depressed, hopeless
CARDIOVASCULAR ☐ WDL: HR and rhythm regular, denies chest pain & palpitations, skin warm & dry. + pulses in all extremities, no edema. ☐ WDL except deviations noted→	☐ Irregular HR ☐ Edema ☐ +1 ☐ +2 ☐ +3 ☐ +4 Location_____ ☐ Peripheral pulse(s) not palpable (specify)_____ ☐ Extremities equal in color, temperature and sensation
RESPIRATORY ☐ WDL: Regular rate depth and pattern, no cough or shortness of breath; breath sounds equal and clear. ☐ WDL except deviations noted→	☐ adventitious lung sounds ☐ crackles wheezes ☐ diminished ☐ short of breath at rest/exertion ☐ use of supplemental oxygen___L ☐ cough ☐ productive ☐ dry ☐ persistent
GASTROINTESTINAL ☐ WDL: Appears well nourished, regular stool pattern, BS present in 4 quadrants, abdomen soft/NT, good appetite. ☐ WDL except deviations noted→	☐ constipation ☐ diarrhea ☐ nausea ☐ vomiting ☐ heartburn ☐ fair appetite ☐ poor appetite ☐ ☐ abdomen firm to palpitation ☐ distended abdomen ☐ incontinence
GENITOURINARY ☐ WDL: no abnormalities in voiding/ability to empty bladder, color or characteristics of urine ☐ WDL except deviations noted→	☐ urgency ☐ dysuria ☐ nocturia ☐ oliguria ☐ urinary frequency ☐ urine odor ☐ incontinence ☐ cloudy ☐hematuria
MUSKOSKELETAL ☐ WDL: no swelling or tenderness in joints; no overt deficits noted, full active movement of all extremities. Not at risk for falls; no recent falls. ☐ WDL except deviations noted→	☐ unsteady gait ☐ impaired ROM ☐ weakness ☐requires assistance to ambulate ☐to transfer OOB/OOC ☐ ambulatory assist drives ☐ walker ☐ crutches ☐ cane ☐ wheelchair ☐ Fall prevention reinforcement
SKIN ☐ WDL: No skin breakdown noted, color consistent with ethnicity. No abnormalities in temperature, moisture, turgor. ☐ WDL except deviations noted→	☐ dry skin ☐ dry mucus membranes ☐ discoloration: location_____ ☐ skin breakdown: describe_____ ☐incision, location & description_____
PAIN/COMFORT ☐ Denies pain ☐ Pain currently present→ ☐ Pain experienced since last visit→	Pain location_____ relief measures_____ Precipitating factors_____ Quality/description_____ Radiates_____ Severity ☐ 1-3 ☐ 4-6 ☐ 7-10 Timing: onset, frequency, duration_____
ENDOCRINE ☐ N/A if no history of diabetes ☐ WDL: Glucose well controlled. No episodes of hypoglycemia or hyperglycemia	☐ Last FS_____ ☐ FS Range_____
☐ Medication Changes, see nursing notes for changes ☐ N/A	☐ Medication profile updated ☐ Pharmacy/Agency notified

ACESS DEVICE CARE: ☐ PIV ☐ Port ☐ Tunneled Catheter ☐ PICC ☐ Midline ☐ SC Line Brand_____ Length_____Gauge_____ Internal length_____cm Access Location_____ Date Placed__/__/____	Exact Cath Measurement_____cm Arm circ, 2" above site_____cm ☐ Dressing CDI ☐ + blood return ☐ patient No. of lumens_____ ☐ Sutures intact x_____ ☐ flush: saline_____ml Heparin___units____ml ☐ n/a	☐ Chills ☐ Fever ☐ Night sweats ☐ Redness ☐ Drainage ☐ Occluded ☐ Swelling ☐ Cording ☐ Tenderness ☐ Flinching	☐ Sterile site care: ☐ Chlorhexidine ☐ Alchohol/betadine ☐Skin prep ☐ Steri-strips ☐ Biopatch ☐ Securement device ☐ Tegaderm ☐ Sorbaview ☐ Opsite ☐ Gauze/tape dressing ☐ Other_____ ☐ Cap Change x_ ☐ Extension tubing change x__ Access insertion x___attempts
LABS DRAWN ☐_____→ ☐ N/A		**Peripheral site**_____☐ Central Line draw **Processing lab**_____ **X**_____**attempts**	

Medications Administered: Pre-Meds_____**Time:**_____
Include drug, dose, diluent, rate, infusion time: **Administered by: ☐ Patient ☐ RN ☐ Caregiver**
MEDICATION_____**TIME:**_____
MEDICATION_____**TIME:**_____
MEDICATION_____**TIME:**_____

☐ **PATIENT EDUCATION PROVIDED** ☐ Medication management (specify)_____ ☐Access device care ☐ Nutrition
☐ Safety enhancement ☐ Bag change ☐Infection control ☐ Aseptic technique, hand washing ☐ Pump alarms and troubleshooting
☐ Hydration ☐ Disease process ☐ Pain management ☐ other_____

Next Nursing Visit___/___/_____**RN Name, credentials**_____ **RN Signature**_____

InfuCare Rx
SPECIALTY INFUSION SERVICES

PROGRESS NOTES

Patient Intravenous Documentation Flow Sheet

Date:_____ Patient Name:_____

Affix label for Immune Globulin bottles here (If not available write lot #s & expiration date for each bottle)

*****Vital Signs @ 15min x 1 hour, then every hour until completion*****

Time	RATE ML/HR	B/P	PULSE	RESP.	COMMENTS (problems/tolerance during infusion)

Comments/Patient response to treatment:

_____

_____

_____

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_____

RN Signature_____**Date**_____

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