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:

_____

_____

_____

_____

_____

RN Signature_____**Date**_____

2540 Market Street Suite 1 Aston PA 19014-3437 PH: 877-828-3940 Fax 877-828-3941

HISTORY AND PHYSICAL ASSESSMENT

PATIENT DEMOGRAPHIC

Account#_____
Name_____ Sex_____
DOB_____ Age____ Ht____ Wt____ Usual Wt____
Primary Dr_____ Secondary Dr_____
Therapy: Enter Drug Solution, Dose, Route, Freq

Allergies: _____
Diet: _____
Functional Limitations: _____
Activity Restrictions: _____
Safety Needs: _____
Infusion Devices: _____
Language: _____ Interpreter: _____
Caregiver: _____ Relation: _____
Emergency Contact: _____ Phone: _____

Vital Signs:

BP: Sitting_____ Standing_____ Lying_____
Pulse_____ Reg_____ Irreg_____ Resp_____
Time_____

MEDICAL/SURGICAL HISTORY

No Sig. Med. Hx ☐
Check all that apply within description:

Chemical Dependency _____
Head/Neck _____
EENT_____
Glasses: Yes____ No____
Endocrine _____
Skin _____
Immune _____
Musculoskeletal _____

Neuro _____
Resp _____
CV _____
GI _____
GU _____
OBGYN _____
Pain _____
Psy/Soc _____
Other _____

Recent Immunizations _____
Hx of Present Illness _____
Other: _____

Surgeries (Enter Surgeries and Dates) No Surgeries ☐

THERAPY ACCESS

Vein Status: Good____ Fair____ Poor____ N/A____
Access Device _____ Brand_____ #Lumen_____
Length_____ Gauge_____ Exposed Cath Length _____
Location_____ Tunneled?_____ Insert Date _____
Inserted By _____ CVC Tip Location _____
Comments: _____

Site Condition: Clean & Dry _____ Drainage _____
Red____ Tender___ Bruised___ Infiltrated___ Sutures____
Phlebitis: 0__ 1__ 2__ 3__ 4__ Arm Circ. _____
Dressing: Gauze & Tape____ Transparent____ Other_____
AB Ointment___ Comments: _____

REVIEW OF SYSTEMS

Head and Neck

WNL___ Masses_____ Deformity_____ Alopecia_____
Circ.___ Other_____

Eyes

WNL___ Blood_____ Discharge_____ Itching_____
Jaundice_____ Redness_____ Tearing_____
Other_____

Nose

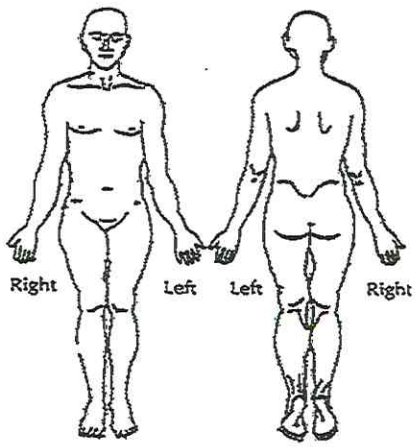
WNL___ Congestion____ Discharge_____ Epistaxis____
Other_____

Mouth & Throat

WNL___ Full Dentures_____ Partial Dentures_____
Lesions_____ Thrush/Candidiasis_____ Inflamed_____
Dysphagia/Aphagia____ Other_____

Skin

WNL___ Pain___ Cyanotic___ Flushed___ Warm___ Cool___
Bruises___ Rash___ Dry___ Tenting___ Lesions___
Mottled___ Petechial___ Jaundiced___ Incisions____
Wounds____
Desquamation___
Decubitus___
Stomas___
Colostomy___
Ileostomy___
Conduit___
Other: _____



HISTORY AND PHYSICAL ASSESSMENT

Neurological
WNL___ Headache___ Disoriented___ Forgetful___
Memory Loss___ Paresis___ Paresthesia___
Numbness___ Paralysis___ Hemiplegic___
Paraplegic___ Spasms___ Tremors___ Seizures___
Dizziness___ Vertigo___ Gait Problems___
Impaired Speech___ Unresponsive___ Other_____

Respiratory
CLR___ SOB___ Dyspnea___ DOE___ Orthopnea___
Breath Sounds: Absent_____, Diminished_____,
Rales_____, Wheezes_____, Tubular_____
Cough: Dry____ Productive____ Sputum Color_____
Tracheostomy____: Secretions____, Suctioned____
O_2___:___ LT/Min: Continuous___, PRN____, Tank___,
Concentrator___, Liquid___, Breathing Tx: _____
Ventilator___: $\%O_2$____ PEEP____ CPAP____
Other: _____

Gastrointestinal
WNL___ Nausea___ Vomiting___ Diarrhea___ Blood___
Constipation___ Cramping___ Heartburn___ Stoma___
Bowel Sounds: Active___ Hypo___ Hyper___ Absent___
Abdomen: Soft___ Distended____ Tight___ Tender___
Other: _____

Reproductive
WNL___ Dysmenorrhea___ Amenorrhea___
Menopause___ Post-Menopausal___
Gravid___ Para___
Pregnant: Gestation Week_____ Postpartum_____
Discharge___ Impotence___ Other: _____

Psychological
WNL___ Anxious____ Depressed____ Angry____
Mood Swings____ Sleep Problems____ Withdrawn____
Developmental Needs: _____
Support Systems: _____
Advanced Directives: In Place_____ Not Executed_____
Discussed_____
Resuscitation: Yes___ No___ DNR Order: Yes___ No___

Musculoskeletal
WNL___ Amputation____ Atrophy____ Contractures____
Spinal Problems____ Joints: Tenderness___ Swelling___
Decreased ROM____ Assistive Devices_____
Other: _____

Endocrine
WNL___ Diabetes___ Other: _____

Cardiovascular
WNL___ Irregular Pulse___ Tachy___ Brady___ Murmurs___
Palpitations____ Chest Pain____ SOB____ Extra Sounds___
Distended Neck Veins___ Hypotensive___ Hypertensive___
EDEMA: 1+___ 2+___ 3+___, Non-Pitting___, Location_____
Peripheral Pulses: (0, 1+, 2+, 3+, 4+)
Rt Radial____ Lt Radial____ Rt Pedal____ Lt Pedal____
Other: _____

Genitourinary
WNL___ Frequency____ Urgency____ Burning___ Pain____
Incontinence: Catheter___ Incontinent Product_____
Urine: Cloudy___ Bloody___ Sediment___ Color_____
Genitalia: Discharge___ Inflamed___ Lesions___ Masses___
Breasts: Asymmetrical____ Lumps/Nodes____ Tender____
Discharge____ Lumpectomy____ Mastectomy____
Other: _____

Pain Assessment
No Pain___ Location: _____ Continuous____
Intermittent___ Quality_____ Intensity (1-10) _____
Exacerbated by_____
Alleviated by_____

Environment
Residence_____ Condition: Clean___ Unclean___
Cluttered___ Pets___ Adeq. Storage___ Adeq. Workspace___
Utilities: Clean water____ Electricity____ Heat____
Telephone____ Refrigerator____
Hazards Checked & Discussed: Fire____ Electrical____ Falls___
Poisons___ Severe Weather___ Evacuation___ BR Safety____
Recommendations: _____
Safe Home: Yes___ No___ C/G Capable & Willing: Yes__ No__ NA__
Overall Candidacy for Home Care: Good___ Fair___ Poor___
Need for other services: _____

Narrative (SOAP Preferred) _____

Next Scheduled Visit: _____

Signature: _____ License #: _____ Date: _____

InfuCare Rx
SPECIALTY INFUSION SERVICES

Patient/Caregiver Instructional Checklist

Topic (check all that apply)	Instruction Date	Init.	Demo Date	Init.	Comments
1. Introduction to InfuCare services ☐ Patient rights and responsibilities ☐24hr on-call RNs and RPHs					
2. General Therapy Information ☐Reason for therapy ☐Side effects discussed ☐Medication Sheet given ☐Self Monitoring_____ ☐Pump Instruction w/ Written Info ☐Trouble Shooting Brand_____ ☐How to Keep Pump Clean ☐ Pre Meds for Side effects					
3. Aseptic Techniques ☐Universal Precautions ☐General Procedures ☐Handwashing					
4. Treatment Administration ☐Preparation of Syringe ☐Tubing Changes ☐Needle/Cannula Changes ☐Direct Connection ☐Start/Stop Infusion ☐Heparin/Saline Flush					
5. Catheter Care ☐Dressing Change ☐Per Protocol Sterile ☐Per Protocol Clean ☐Variation_____ ☐Injection Cap Change ☐Routine Flushing_____ ☐Lab Draw by PT/CG					
6. Catheter Complications ☐Infection ☐Phlebitis ☐Infiltration ☐Occlusion ☐Breakage					
7. Chemo Precautions ☐Protective Gear ☐Handling bodily fluids and secretions ☐Immune Suppression Precautions					
8. Home Safety Hazards Discussion ☐Safety Checklist Given ☐PT/CG Acknowledge Responsibility for Safe Home ☐Emergency Numbers Reviewed ☐Severe Weather Instructions Reviewed					
9. Advance Directives Discussed Copy for Chart ☐Yes ☐No					
10. Supplies ☐Deliveries ☐Waste Disposal ☐Sharps Container Use					

THE ABOVE INFORMATION HAS BEEN REVIEWED IN A LANGUAGE AND METHODS THAT I UNDERSTAND. IT IS MY RESPONSIBILITY TO CARRY OUT PROCEDURES AND SKILLS AS INSTRUCTED. I UNDERSTAND THAT THE DURABLE EQUIPMENT REQUIRED FOR MY THERAPY IS THE PROPERTY OF INFUCARE RX, INC. AND IS TO BE RETURNED TO THE COMPANY IN THE SAME CONDITION IT WAS RECEIVED.

PATIENT/CAREGIVER SIGNATURE_____RELATION_____DATE_____

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

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

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

No.	NURSING EXPCTED OUTCOMES	ACTIVE DATE	INIT.	ACTION PLAN	MODIFICATION REVIEW	DATE	INIT.	RESOLVE DATE	INIT.
1.	Deficit in knowledge of health maintenance resources			a.) HomeCare Rx representatives will inform Pt/CG of their rights and responsibilities b.) Homecare Rx will introduce the company and services offered and method of supply/delivery c.) Pt/CG will be informed of RN and Rph availability 24hrs/day 7days/week. d.) Have the Pt/CG sign the agreement for services which includes financial arrangements e.) Pt/CG will indicate acceptance of the care responsibilities by signing the teaching checklists f.) HomeCare Rx will coordinate and discuss "Advance Directives" leaving a brochure in the home g.) HomeCare Rx will coordinate infusion care with other homecare agencies when necessary h.) Nursing Care to be done by_____agency					
2.	Altered_____ R/T_____ Pt/CG will_____ _____ _____ _____			a) Instruct the Pt/CG on the rational for Home Therapy b) HomeCare Rx to Monitor labs every_____ c) Labs to be reported to:_____ d) RN to monitor progress toward therapy goals every_____ e) Instruct Pt/CG to monitor I & O:____Temp:___ Weight:____Drainage:____Wound_____ Other:_____ f.) Pt/CG to report significant changes in condition to HomeCare Rx or Dr._____office.					
3.	Knowledge deficit R/T home therapy. Pt/CG will be independent in the safe administration of _____via the _____system			a.) Instruct Pt/CG to monitor for any side effects to therapy: report to HomeCare Rx or their Dr. should they occur b.) Discuss the drug information sheet with the Pt/CG and leave sheet in the home for reference c.) Demonstrate with return demo the administration set up and use of the _____system					

RN Sig._____Date_____Init.____ RN Sig._____Date_____Init.____ RN Sig._____Date_____Init.____	RN Sig._____Date_____Init.____ RN Sig._____Date_____Init.____ RN Sig._____Date_____Init.____	RN Sig._____Date_____Init.____ RN Sig._____Date_____Init.____ RN Sig._____Date_____Init.____

No.	NURSING EXPCTED OUTCOMES	ACTIVE DATE	INIT.	ACTION PLAN	MODIFICATION REVIEW	DATE	INIT.	RESOLVE DATE	INIT.
3.	(CONTINUED)			d.) Instruct Pt/CG on troubleshooting the administration system: ALARMS_____AIRLOCKS_____LEAKS_____ CRIMPED TUBING_____ELECTRIC SOURCE_____BREAKAGE_____ e.) HomeCare Rx to monitor for drug interactions via med. profile. f.) RN to do all therapy					
4.	Knowledge deficit about aseptic technique. Pt/CG will maintain good aseptic techniques during procedures and experience no contamination			a.) Provide written instructions that outline aseptic techniques b.) Demonstrate with a return demonstration, aseptic technique: Hand washing__Aseptic use__Do not touch sterile tips___Donning gloves___Clean work space____ Wearing a mask_____					
5.	Altered Skin/Vascular Integrity R/T medication access device. Pt/CG will have no therapy interruption due to access device complication			a.) Inform Pt/CG about type of device: CVC___Periph___ PICC____Midline___Port___SubQ___ device. b.) Instruct Pt/CG to monitor for signs and symptoms of phlebitis and infection. Temp___ Rednesss___Tenderness___Swelling___Drainage___Cord Formation___Increased Vasculature___ c.) Instruct Pt/CG to access device dressing change___Sterile every_____ Clean every_____ d.) RN to do dressing changes e.) Instruct Pt/CG to flush access device with ___NS___ccs___Heparin___U/ml___ccs____ f.) Pt/CG to change injection cap every_____ g.) RN to do Injection Cap Change					
6.	Knowledge deficit regarding universal precautions			Instruct the Pt/CG to: a.) Avoid contact with bodily secretions and blood b.) Not to recap needles____Safely recap needles c.) Use needless systems d.) Dispose of all sharps and medical waste properly e.) Clean equipment supplies and lines as indicated f.) Wear gloves____gowns_____when indicated g.) Notify MD and HomeCare RX should exposure occur					
RN Sig._____Date_____Init.____ RN Sig._____Date_____Init.____ RN Sig._____Date_____Init.____				RN Sig._____Date_____Init.____ RN Sig._____Date_____Init.____ RN Sig._____Date_____Init.____	RN Sig._____Date_____Init.____ RN Sig._____Date_____Init.____ RN Sig._____Date_____Init.____				

No.	NURSING EXPCTED OUTCOMES	Active Date	INIT.	ACTION PLAN	MODIFICATION REVIEW	DATE	INIT.	RESOLVE DATE	INIT.
7.	Potential for ineffective coping with illness and/or illness outcomes within his/her cultural perspective. Pt/CG will use effective resources to make informed care disclosures			a.) Encourage verbalization of illness/care concerns between home members and health care team b.) Emphasize use of appropriate support groups i.e hospice, Oley, AIDs and Lyme organizations and cultural centers and groups c.) Arrange for interpretive services as needed d.) Encourage appropriate spiritual/emotional counselling e.) Encourage development of temporary alternative					
8.	Potential for altered protection R/T physical and/or emotional risks Pt/CG will maintain safe home environment and take appropriate precautions should risks arise			a.) Present home safety information to the Pt/CG. Leave info in the home as a reference b.) R.N. to check for obvious safety hazards in the home c.) R.N. to correct if possible, or recommend correction of obvious hazards d.) Referral to appropriate resources should home be grossly unsafe (fire dept., public health dept., state hot lines) e.) Review emergency plans for continuation of services during inclement weather f.) Encourage Pt/CG to perform safety check of household using home safety information as a guide					
9.	Pt's nutritional risk of: Zero___. Low___Mod___High___ resulting in possible altered nutritional requirements Pt's nutritional status will stabilize or improve Pt will follow_____diet throughout therapy or until order for change			a.) Encourage adherence to any prescribed diet utilizing cultural food preferences when possible b.) Offer dietary information or refer patient to culturally knowledgeable nutritionist/dietician for education/counselling c.) Encourage adherence to supplements, TPN or Enteral regimen. (Refer to previous therapy problem in Care Plan). Supplements/snacks d.) Pt. to be NPO e.) Encourage adequate fluid intake					
10.	Need for early discharge planning Pt./CG will be included in and agree with plans for discharge			a.) Expected discharge date:_____ b.) No expected discharge date due to:_____ c.) Pt will be discharged to: Self-care____ Caregiver_____ d.) Refer or transfer to_____ for continued service or follow up in the areas					

RN Sig._____Date_____Init.____	RN Sig._____Date_____Init.____	RN Sig._____Date_____Init.____
RN Sig._____Date_____Init.____	RN Sig._____Date_____Init.____	RN Sig._____Date_____Init.____
RN Sig._____Date_____Init.____	RN Sig._____Date_____Init.____	RN Sig._____Date_____Init.____

MEDICATION PROFILE

Patient Name:_____ Physician:_____

Allergies:_____ Phone:_____

DIAGNOSIS:_____

DATE	DRUG NAME / DOSE	ROA	FREQ	COMMENTS	DC DATE

***PLEASE LIST ALL PRESCRIPTION AND NON-PRESCRIPTION MEDS, HOME REMEDIES, AND INVESTIGATIONAL AGENTS.
***PLEASE INCLUDE ALL HPC THERAPIES

RN SIGNATURE:_____ DATE:_____

MD SIGNATURE:_____ DATE:_____

InfuCare Rx
SPECIALTY INFUSION SERVICES

PATIENT'S BILL OF RIGHTS & RESPONSIBILITIES

As a patient you have the right to:

1. Be informed of your rights both verbally and in writing at the time of admission and prior to the initiation of care.
2. To participate in the selection of your home care provider, to communicate with them in a language or form you can understand prior to service.
3. Receive competent, individualized care and service regardless of age, race, color national origin, religion, sex, disease, disability or any other category protected by law or decisions regarding advance directives.
4. Be treated with dignity, courtesy, consideration, respect and have your property treated with respect.
5. Be informed verbally and in writing of the services available and related charges, as they apply to the primary insurance, other payers, and self-pay coverage before it is initiated. To be informed of any changes in in the sources of payment and your financial responsibility as soon as possible but no later than thirty (30) days after the provider is notified.
6. Be informed both orally and in writing, in advance of the Plan of Care, of any changes in the Plan of Care, and to be included in the planning of care before treatment begins of all treatment prescribed, when and how services will be provided and the names and functions of any person and affiliated program providing care and services, including photo identification of agency staff and participate in the development of the discharge plan.
7. Participate in the planning of your care and be advised of any changes to the Plan of Care and to be transferred to another organization and/or be informed of impending discharge from service, as well as any continuing care needs or services, in a timely manner, as your condition progresses or changes
8. To receive training in the prescribed home therapy to include:
    a. Reasons for treatment and use of supplies and equipment
    b. Possible risks and side effects of treatment.
    c. Written instructions and demonstration by a registered nurse
    d. Supervision by a registered nurse until you are able to perform required tasks safely
9. Refuse care and treatment after being fully informed of and understanding the consequences of such actions and to initiate an Advance Directive, "Living Will" durable power of attorney and other directives about your care consistent with applicable laws.
10. To receive an appropriate assessment of pain and management of pain.
11. Receive information regarding community resources and be informed of any financial relationships between Home Rx Inc. and other providers to which you may be referred to by the agency.
12. Be informed of the procedures for submitting patient complaints, voice complaints and recommend changes in the policies to Patient Services by calling 877-828-3940. If dissatisfied with the outcome you may also contact the New Jersey State Department of Health or any outside agent of the patient's choice. The expression of any such complaints by the patient shall be free from interference, coercion, discrimination or reprisal.
13. Express complaints about the care and services provided or not provided and complaints concerning lack of respect for property by personnel furnishing services and to expect the agency to investigate such complaints within 15 days of receipt. Also, if dissatisfied with the outcome, may submit an appeal to the agency's governing authority which will be reviewed within 30days of receipt.
14. To be informed of any alternatives to your prescribed treatment and any risks and benefits associated with the alternatives.
15. To be allowed to participate (or not) in any investigational studies relevant to your diagnosis, after being informed of the risks and benefits of the treatment.
16. Receive timely notice of impending discharge or transfer to another agency or to a different level of care and to be advised of the consequences and alternatives to such transfers.
17. Privacy including confidential treatment of records, and access to your health records on request. Information will not be released without your written consent except in those instances required by law regulation or third party reimbursement
18. In the situation when the patient lacks capacity to exercise rights, the rights shall be exercised by an individual guardian or entity legally authorized to represent the patient.

As a Home Care Patient, you have the responsibility to:

1. Be seen by a doctor on a regular and ongoing basis and share complete and accurate health information regarding your medical history, condition and response to treatment.
2. Participate in the planning of and be responsible for following the recommended plan.
3. Carry out your therapy as instructed and make it known if you do not understand or cannot follow the treatment plan.
4. Cooperate with agency staff and not discriminate against staff. Be available to co. staff for delivery and nursing visits
5. Notify the Home Infusion Provider in advance when you cannot keep an appointment.
6. Maintain a safe home setting for storage of medication, administration of care and maintain confidentiality of any and all medical documents that may be left in the home.
7. Notify the agency in the event of readmission to hospital, out-of-town-plans or changes in address/phone.
8. Be responsible for your actions if you refuse treatment or do not follow the agency's recommendations
9. Take responsibility for financial obligations of your care.

Patient/Representative Signature_____Date_____

InfuCare Rx
SPECIALTY INFUSION SERVICES

PRIVACY NOTICE

InfuCare Rx is required to maintain the confidentiality of your Healthcare information. The following notice describes how your medical information may be used and disclosed by InfuCare Rx as well as your rights regarding access to this information. Please review this notice carefully.

Your confidential healthcare information may be released:

- ✓ To healthcare professionals within our organization for the purposes of providing you with quality home care
- ✓ To Physicians, healthcare agencies and pharmaceutical providers who are directly involved with your care
- ✓ To your insurance provider for the purpose of receiving payment for the healthcare services provided to you
- ✓ To other healthcare providers in the event that you need emergency care
- ✓ To Public or Law enforcement officials in the event of an investigation of a crime in which you are a victim

Your confidential healthcare information **MAY NOT** be released for any other purpose than that which is identified in this notice. Your confidential healthcare information may be released to individuals or entities not set forth in this notice only after receiving written permission from you. You also have the right to revoke this permission to release confidential healthcare information at any time.

You have certain rights regarding your confidential healthcare information which include:

- ✓ The right to restrict the use of your confidential healthcare information. However, InfuCare Rx may refuse your restriction if it is in conflict with applicable federal or state laws, the delivery of quality healthcare or in the event of an emergency situation.
- ✓ The right to receive confidential communication about your health status
- ✓ The right to review and photocopy and/all portions of your healthcare information
- ✓ The right to make changes to your healthcare information.
- ✓ The right to request an accounting of the uses and disclosure of your confidential healthcare information for a period of six years prior to your request. This accounting applies to disclosures to individuals or business associates other than for the purposes of treatment, payment and healthcare options.
- ✓ The right to receive information regarding InfuCare Rx duties, use and disclosure practices associated with confidential healthcare information
- ✓ The right to receive a copy of this Privacy Notice upon request, which can be in electronic or paper form

You have the right to further information regarding this Privacy Notice, as well as the right to complain to our facility if you believe your rights to privacy have been violated. All complaints to our facility will be investigated and held confidential without fear of reprisal. For further information and/or to submit a complaint you may contact the individual named below by telephone or by mailing your inquiry and or complaint to:

Walter Stielau, PharmD
InfuCare Rx, Inc.
2540 Market Street Suite 1
Aston PA 19104
877-282-3490

This notice is effective March 1, 2015. If the patient lacks the capacity to sign this service agreement, this agreement may be signed by an individual or entity legally authorized to represent the patient.
Signature or Patient or Legal Representative_____Date_____

InfuCare Rx
SPECIALTY INFUSION SERVICES

1. PATIENT SELF DETERMINATION ACT & BILL OF RIGHTS
I have received a written statement of my rights as a patient of the Provider. I understand my rights because they have been explained to me and my questions have been answered. I have received verbal information about advance directives, company policy, applicable state law, my rights under state law, and other information necessary to make decisions about advance directives and my care in accordance with the Patient Self Determination Act of 1990.

2. RELEASE OF INFORMATION
I consent to release of information by my Physician, Licensed Health Care Professionals, or Facility and to allow the disclosure of medical records kept by the above Provider. I consent to the release of information by the Provider or their representatives to representatives of other health care providers involve in my care and other third party payers in order to insure continuity of treatment, proper communication of information to my physician(s) and referral source, and proper reimbursement of services

3. CONSENT FOR TREATMENT
I voluntarily consent to receive treatment from the Provider consistent with a medical treatment plan authorized by my physician. I understand that if I am in such condition as to need services not provided by Provider, such services must be arranged by me or my legal representatives, or my physician. The Provider shall assist in locating such services, but shall in no way be responsible for failure to provide the same, and is hereby released from any and all liability arising from the fact that I am not provided with such additional care. In the event a health care worker sustains exposure to my blood or bodily fluids, I give permission for my blood to be tested for infectious diseases such as HIV or Hepatitis. I understand that the exposed employee will be informed to the results of the test. I understand that I will be billed for any lab fees incurred should the employee sustain any exposure.

4. PAYMENT AUTHORIZATION AND ASSIGNMENT OF BENEFITS
I hereby authorize_____ to make payments directly to the Provider for authorized services provided. In consideration of Provider's agreement to forego collection of my account for a reasonable period of time, I hereby assign to Provider or it's legal representative, all of my rights, including the right to sue on my behalf or name under policy#_____ issued by _____ to recover charges for services rendered by the Provider. This assignment shall not extinguish or diminish my obligation to pay the full fee to the Provider for services rendered, but I shall receive credit for all sums collected pursuant to this agreement. If I enroll in another insurance plan it is my responsibility to notify the Provider otherwise I will be responsible for payment.

I understand that my insurance has agreed to pay _____% of allowable charges after meeting a deductible of_____. I understand that I am responsible for_____% after my deductible has been met.

5. MEDICARE (Part B outpatient)_____ (CHECK IF NOT APPLICABLE)
I certify that the information given to me in applying for payment under Title XVIII (Medicare) of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or it's intermediaries or carriers any information needed for this or related Medicare claim. I request that payment of authorized benefits be made to the Provider on my behalf. Services covered under Medicare Part B are reimbursed @ 80% and I am responsible for the 20% co-payment plus the deductible when applicable. I will be notified of any changes in the amount of charges for items and services as soon as possible but no later than 30days from the date that the provider becomes aware of the change.

6. CONSENT FOR INFUSION SERVICES
My physician has informed me of the potential risk associated with this therapy. The specifics of therapy, namely why the therapy is used, what specific agents have been prescribed, how these agents will be administered, and my role in providing the therapy have all been discussed with me prior to the initiation of the therapy. All questions regarding my care have been answered to my satisfaction. Therefore I consent to the administration of home infusion therapy. I understand my care will be under the supervision of a registered nurse and my physician.

Signature of Patient or Legal Guardian_____Date_____

Provider Witness_____Date_____

Patient Name:_____
Nursing Supervisor:_____
Patient's Rights/Policy Explained: Date_____
Explained By:_____
DNR: ☐ Yes ☐ No Date:_____
Location:_____
Reviewed:_____
Cancelled (Date)_____
Home Care Proxy: ☐ Yes ☐ No Date:_____
Location:_____
Reviewed:_____
Health Care Agent:_____
Living Will: ☐ Yes ☐ No Date:_____
Location:_____
Reviewed:_____
Cancelled (Date)_____
Durable Medical Power of Attorney: ☐ Yes ☐ No Date:_____
Location:_____
Reviewed:_____
Cancelled (Date)_____

Oral Directives:

Date	Comments	Cancelation Date

	EMERGENCY KARDEX
If you are directed to evacuate from your home due to an emergency situation bring this form along with your emergency supplies. This form contains important medical information and will assist the emergency management volunteers to direct you to appropriate services. KEEP THIS FORM IN A SAFE AND ACCESSIBLE LOCATION	
Name:	Date of Birth:
Address:	City/Town/Village:
Telephone:	
#1 Emergency contact (Local):	Telephone#
#2 Emergency contact	Telephone#
Physician:	Telephone#
Physician:	Telephone#
Hospital Used:	
Pharmacy:	Telephone#
Medical Supplier/Oxygen Provider:	Telephone#
Medical History:	
Medications: Self-Administered ☐ Yes ☐ o IF NO, identify individual responsible	
List all medications:	
Advance Directives: ☐ Yes (Attach copy) ☐ No Proxy:	
DNR ☐ Yes (Attach copy) ☐ No	
Allergies:	Diet Needs:
Mental Status:	Community Agencies involved:
Daily care required:	
Please put together an emergency bag that contains the following: Bedding, Blanket, Snacks, Water, Medication list, Medical supplies, Personal care items i.e. comb/brush, Toothbrush/paste, clothing, equipment i.e. walker, wheelchair and personal identification and health insurance ID card. Remember to take your medications with you.	

InfuCare Rx
SPECIALTY INFUSION SERVICES

HIPAA email consent

VERY IMPORTANT! PLEASE READ!

- HIPAA stands for the *Health Insurance Portability and Accountability Act*
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored on our computers is encrypted
- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email
- **When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.**
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA
- The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website - http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email

OPTION 1 – **ALLOW** UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to Infucare Rx to send me personal health information via unencrypted email.

Signature (parent or guardian if patient is a minor)	Date	Printed name	Please print email address
_____	_____	_____	_____

OPTION 2 – **DO NOT ALLOW** UNENCRYPTED EMAIL

I do not wish to receive personal health information via email

Signature (parent or guardian if patient is a minor)	Date	Printed name
_____	_____	_____