HomeCare Rx

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**_____

HomeCare Rx

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**_____

695 Route 46 West, Suite 100 Fairfield, NJ 07004 PH: 877-920-2090 Fax 877-920-0466

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_____

Temp_____

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___

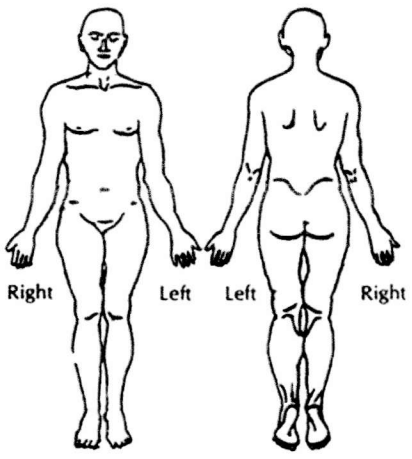
Other: _____

_____

_____

_____

_____



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:_____

	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.	

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.	RESOLV DATE	INIT.
1.	Deficit in nowledge of health maintena ce resources			a.) HomeCare Rx r presentatives will infor n Pt/CG of their rights and resp nsibilities b.) Homecare Rx w ll Introduce the compa y and services offered and me hod of supply/delivery c.) Pt/CG will be in ormed of RN and Rph a vailability 24hrs/day 7day /week. d.) Have the Pt/CG ign the agreement for ervices which includes financi l arrangements e.) Pt/CG will indic te acceptance of the ca e responsibilities by signing the t aching checklists f.) HomeCare Rx w ll coordinate and discu s "Advance Directives" leav ng a brochure in the hc ne g.) HomeCare Rx w ll coordinate infusion c re with other homecare agen ies when necessary h.) Nursing Care to be done by_____ _____agency					
2.	Altered__ _____ R/T_____ _____ Pt/CG wil _____ _____ _____ _____ _____ _____ _____			a) Instruct the Pt/ G on the rational for H me Therapy b) HomeCare Rx t Monitor labs every___ _____ c) Labs to be repo ted to:_____ _____ d) RN to monitor p ogress toward therapy goals every_____ _____ e) Instruct Pt/CG t monitor I & O:____Te np:___ Weight:____Dr inage:____Wound____ __ Other:_____ _____ f.) Pt/CG to report ignificant changes in cc ndition to HomeCare Rx or Dr. _____ office					
3.	Knowledg e deficit R/T home therapy. Pt/CG wil be independent in the safe admi istration of _____ _____via the _____ _____system			a.) Instruct Pt/CG t monitor for any side e fects to therapy: report to Home Care Rx or their Dr. sho ld they occur b.) Discuss the dru information sheet witl the Pt/CG and leave sheet in t e home for reference c.) Demonstrate w h return demo the adr inistration set up and use of the _____syster					

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

No.	NURSING EXPCTED OUTCOMES	ACTIVE DATE	INIT.	ACTION PLAN	MODIFICATION REVIEW	DATE	INIT.	RESOLV 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 the apy					
4.	Knowledge deficit about aseptic technique Pt/CG will maintain good aseptic technique during procedures and experience no contamination			a.) Provide written nstructions that outline aseptic techniques b.) Demonstrate with a return demonstration, aseptic technique: Hand washing__Aseptic use _Do not touch sterile tips___Donning gloves____Clear 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 ymptoms of phlebitis and infection. Temp___ Redness___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___cc _____ 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 or ineffective coping w h illness an /or illness outcomes w hin his/her cu tural perspective. Pt/CG wil use effective resources to make infc med care disclosures			a.) Encourage verbalization of illness/care concerns between hom e members and health care team b.) Emphasize us of appropriate support groups i.e hospice, Oley, AIDs and Lyme organizations and cultural cente s and groups c.) Arrange for in erpretive services as needed d.) Encourage ap ropriate spiritual/emotional counselling e.) Encourage de elopment of temporary alternative					
8.	Potential or altered protection R T physical a id/or emotional risks Pt/CG will maintain safe home environm nt and take appropriat precautio s should risks arise			a.) Present home safety information to the Pt/CG. Leave info in the ho ne as a reference b.) R.N. to check or obvious safety hazards in the home c.) R.N. to correc if possible, or recommend correction of obvious hazar ls d.) Referral to ap ropriate resources should home be grossly unsafe (fire dept., public health dept., state hot lines) e.) Review emer ency plans for continuation of services during inclem nt weather f.) Encourage Pt, CG to perform safety check of household using home s fety information as a guide					
9.	Pt's nutrit onal risk of: Zero___. Low___M d___High___ resulting in possible a tered nutritional requirem nts Pt's nutrit onal status will stabiliz or improve Pt will foll w_____di t throughc t therapy or until orde for change			a.) Encourage ad erence to any prescribed diet utilizing cultural food references when possible b.) Offer dietary nformation or refer patient to culturally knowledgeab e nutritionist/dietician for education/co nselling c.) Encourage ad erence to supplements, TPN or Enteral regimen. (Ref r to previous therapy problem in Care Plan). Supplements, snacks d.) Pt. to be NPO e.) Encourage ad quate fluid intake					
10.	Need for arly discharge planning Pt./CG wi be included in and agr e with plan for discharge			a.) Expected disc arge date:_____ b.) No expected ischarge date due to:_____ c.) Pt will be disc arged to: Self-care____ Caregiver_____ d.) Refer or trans er to_____ for continued service or foll w up in the areas					
RN Sig._____ _____**Da te**_____**Init.**____ **RN Sig.**_____ _____**Da te**_____**Init.**____ **RN Sig.**_____ _____**Da te**_____**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:**_____