



ireMEDys

Patients Name: _____

DOB: _____

Today's Date: _____

Nursing Visit Report

Printed Nurses Name: _____

Nurses Signature: _____

Next Infusion Date: _____

Height: _____

Primary Diagnosis: _____

Weight: _____

Change in medications? ☐ No ☐ Yes: _____Gender: ☐ Male ☐ Female ☐ Not specified

Visit Location: _____

Location Environment: ☐ Safe ☐ Unsafe ☐ Other: _____Visit Type: ☐ SOC/Admission ☐ Re-visit ☐ Appointment ☐ On call visitReason for visit (check all that apply): ☐ Medication administration ☐ Teach/Re-Teach☐ Labs Drawn: _____ ☐ Port Access ☐ Dressing Change ☐ PIV access☐ Pump related ☐ Other: _____

Travel starts*: _____ AM/PM Arrival time: _____ AM/PM

Infusion start time: _____ AM/PM Infusion end time: _____ AM/PM

Depart time: _____ AM/PM Travel ends*: _____ AM/PM

Total Patient Time: _____ Total Travel Time*: _____ Total Miles*: _____

PLEASE FILL OUT IF BILLING FOR DRIVE TIME/MILEAGE

Rx Name: _____ Dose: _____

Strength: _____ Rate: _____

Lot #: _____ Expiration Date: _____

Verified with: ☐ Prescriber ☐ Pharmacist ☐ Order ☐ Other: _____

Pump Type: _____

Needle Gauge: _____ Needle Length: _____

Attempts: ☐ 1 ☐ 2 ☐ 3 ☐ Other: _____IV Access Type: ☐ Subcutaneous ☐ Peripheral ☐ Midline ☐ PICC ☐ Port AccessAdmission Site: ☐ Redness ☐ Pain ☐ Swelling ☐ Tenderness ☐ Drainage ☐ Numbness/TinglingSite care provided: ☐ Dressing ☐ Change ☐ Gauze ☐ Transparent ☐ Other: _____



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Is the patient in pain today? ☐ Yes ☐ No

Pain Location: _____

Pain (scale 1-10): _____ ☐ Constant ☐ Intermittent ☐ Burning ☐ Sharp ☐ Stabbing ☐ Achy

Medication used for pain (dose and frequency): _____

Allergies: _____

Is the patient oriented to Person/Place/time? ☐ Yes ☐ No

Does the patient have seizures (how often)? ☐ No ☐ Yes: _____

Does the patient experience headaches? ☐ Yes ☐ No

How often do they experience headaches? _____

Location of the headaches: _____

Pain of headaches on a scale of 1 to 10 (10 being the worst): _____

Does the patient experience numbness (location)? ☐ No ☐ Yes: _____

Does the patient experience tingling (location)? ☐ No ☐ Yes: _____

Does the patient have any difficulty ambulating (specify): ☐ No ☐ Yes: _____

Has the patient been to the hospital within the past 3 months (specify): _____

Does the patient take antidepressants? (dose and frequency): ☐ No ☐ Yes: _____

Is the patient taking any antibiotics (dose/frequency/for what)? ☐ No ☐ Yes: _____

Is the patient taking any steroids (dose/frequency/for what)? ☐ No ☐ Yes: _____

Does the patient experience vomiting or diarrhea (specify and how often)? ☐ No ☐ Yes: _____



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A. Eyes/Ears/Nose/Throat

☐ Visual changes: _____☐ Hearing changes: _____Drainage: ☐ Ears ☐ Nose ☐ Eyes

B. Gastrointestinal

Last BM: ____/____/____

Abdomen: ☐ Soft ☐ Firm ☐ Nontender ☐ TenderBowel Sounds: ☐ WNL ☐ Abnormal: _____

C. Psychosocial

☐ WNL ☐ Depressed ☐ Agitated ☐ Withdrawn ☐ Inappropriate

D. Cardiac

Heart Sounds: ☐ WNL ☐ Abnormal: _____Rhythm: ☐ Regular ☐ Irregular ☐ Palpitations ☐ Angina ☐ SOB☐ Edema (location & scale 1-4): _____

E. Nutrition

Weight change: ☐ Loss: _____ ☐ Gain: _____Appetite: ☐ Good ☐ Fair ☐ PoorFluid Intake: ☐ Good ☐ Poor

F. Genitourinary

☐ WNL ☐ Frequent ☐ Urgency ☐ Pain ☐ Burning ☐ Oliguria

Urine color: _____

Odor: _____

G. Respiratory

☐ SOB ☐ Rest exertion ☐ Dyspnea ☐ OrthopneaBreath Sounds: ☐ Clear R/L ☐ Decreased R/L ☐ Rhonchi R/L ☐ Rales R/L ☐ Wheezes R/LCough: ☐ Productive ☐ Nonproductive

H. Integumentary

Color: ☐ Pink ☐ Jaundice ☐ Cyanotic ☐ Pallor ☐ FlushedSkin: ☐ Warm ☐ Dry ☐ Cool ☐ MoistTurgor: ☐ Good ☐ Fair ☐ PoorIntegrity: ☐ Intact ☐ Bruises ☐ Erythema ☐ Rashes ☐ Abrasions ☐ Lacerations ☐ Wounds

I. Musculoskeletal

☐ Mobile ☐ Steady ☐ Gait ☐ Balanced ☐ Assistive DeviceROM: ☐ Impaired: _____☐ Pain ☐ Weakness: _____



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Infusion Monitoring						
Time	Rate	BP	Pulse	Resp	Temp	Reaction/Comments

COMMENTS:



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