BioTek reMEDys

Nursing Visit Report

Patients Name: _____

DOB: _____

Today's Date: _____

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 visit

Reason 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 Access

Site Condition: ☐Redness ☐Pain ☐Swelling ☐Tenderness ☐Drainage ☐Numbness/Tingling

Site 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 ☐Intermit ☐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 ☐ Tender
Bowel 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 ☐ Poor Fluid Intake: ☐ Good ☐ Poor

F. Genitourinary

☐ WNL ☐ Frequent ☐ Urgency ☐ Pain ☐ Burning ☐ Oliguria
Urine color: _____
Odor: _____

G. Respiratory:

☐ SOB ☐ Rest exertion ☐ Dyspnea ☐ Orthopnea
Breath Sounds: ☐ Clear R/L ☐ Decreased R/L ☐ Rhonchi R/L ☐ Rales R/L ☐ Wheezes R/L
Cough: ☐ Productive ☐ Nonproductive

H. Integumentary

Color: ☐ Pink ☐ Jaundice ☐ Cyanotic ☐ Pallor ☐ Flushed
Skin: ☐ Warm ☐ Dry ☐ Cool ☐ Moist
Turgor: ☐ Good ☐ Fair ☐ Poor
Integrity: ☐ Intact ☐ Bruises ☐ Erythema ☐ Rashes ☐ Abrasions ☐ Lacerations ☐ Wounds

I. Musculoskeletal

☐ Mobile ☐ Steady ☐ Gait ☐ Balanced ☐ Assistive Device
ROM: ☐ Impaired: _____
☐ Pain ☐ Weakness: _____

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Today's Date: _____

Infusion Monitoring						
Time	Rate	BP	Pulse	Resp	Temp	Reaction/Comments

COMMENTS:

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Nursing Visit Report

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DOB: _____

Today's Date: _____

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