

IG Dose Summary



Date: _____

Site of Infusion: ☐ Home ☐ Infusion Suite

Prescriber: _____

Phone: _____ Fax: _____

Patient Name: _____

Intravenous Delivery ☐ Subcutaneous Infusion ☐

Venus Access complications? ☒ Yes ☐ No

Side Effects Experienced: ☐ Yes ☐ No

(0 'None', 1-3 'Mild', 4-6 'Moderate', 7-9 'Very Bothersome', 10 'Severe')

Headache: 0 1 2 3 4 5 6 7 8 9 10

Migraine: 0 1 2 3 4 5 6 7 8 9 10

Nausea: 0 1 2 3 4 5 6 7 8 9 10

Rash: 0 1 2 3 4 5 6 7 8 9 10

Fever:	0	1	2	3	4	5	6	7	8	9	10
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Dyspnea: 0 1 2 3 4 5 6 7 8 9 10

Back or Leg Pain:	0	1	2	3	4	5	6	7	8	9	10
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Chills: 0 1 2 3 4 5 6 7 8 9 10

Intervention: ☐ Pre-medication Administration:

☐ Therapy Completed ☐ Infusion Rate Adjusted ☐ Infusion Stopped ☐ Prescriber Notified

Notes: _____

Next Dose Scheduled for (Date): _____

Patient Feeling of Well Being:

0	1	2	3	4	5	6	7	8	9	10
Very Sad										Very Happy

Thank you letting BioScrip serve you.

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