bioscrip® Infusioncare

ADULT INITIAL PATIENT ASSESSMENT/ CARE PLAN

Form CLIN-GEN24-01

Date:_____ Time In:_____ Time Out:_____

PATIENT NAME: (Last, First)

HOME PHONE: WORK/CELL PHONE:

DOB: AGE: SEX: ☐ M ☐ F

ADMIT: ☐ HOME ☐ HOSPITAL ☐ CLINIC ☐ DRS. OFFICE ☐ OTHER _____

Person Providing Information: ☐ *SELF* ☐ *OTHER:*_____

GENERAL INFORMATION

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

OCCUPATION: _____

LANGUAGE SPOKEN: ☐ **English** ☐ **Other:**_____

SIGNIFICANT OTHER:_____

EMERG.CONTACT:_____

RELATIONSHIP:_____

RELATIONSHIP:_____

PHONE:_____

PHONE:_____

PHYSICIAN 1:_____

DIAGNOSIS 1: _____

PHYSICIAN 2: _____

DIAGNOSIS 2: _____

CODE STATUS: ☐ Resuscitate ☐ Do Not Resuscitate (If DNR, must have signed copy in home)

LIVING WILL/ADVANCE DIRECTIVES: ☐ No ☐ Yes If Yes, explain briefly: _____

PRESENT MEDICAL HISTORY

Diabetic? ☐ No ☐ Yes **Insulin Dependent?** ☐ No ☐ Yes

ETOH Use?: ☐ No ☐ Yes-Use:_____ **Drug Abuse?:** ☐ No ☐ Yes-Use:_____ **Smokes:** ☐ No ☐ Yes **PPD:**_____

Allergies? : ☐ No ☐ Yes If Yes, List: # of Pack Years:_____

TB Status: ☐ Active ☐ Unknown PPD Neg. Date: **Other Infectious Disease:** ☐ No ☐ Yes: ☐ Airborne ☐ Droplet ☐ Contact

Present Symptoms and Duration per patient/caregiver

Recent Treatments/Hospitalizations:

PAST MEDICAL HISTORY

☐ **No pertinent medical history**	☐ Musculoskeletal	☐ Metabolic
☐ Respiratory	☐ Communicable Disease	☐ Psychosocial
☐ Neurological	☐ GYN/GU	☐ Eye, Ear, Nose, Throat
☐ Gastrointestinal	☐ Cardiovascular	☐ Integumentary

If "Yes", Explain:

Past Surgery: ☐ None

VITAL SIGNS

T_____ P_____ R_____ B/P_____/_____ (☐ L Arm ☐ R Arm - ☐ Sitting ☐ Standing) **HT.**_____ **WT.**_____

Comments: _____

RESPIRATORY
Assess: chest configuration, resp. rate, rhythm, depth, breath sounds, comfort

- ☐ NO PROBLEM
- ☐ asymmetric
- ☐ cyanotic
- ☐ tachypnea
- ☐ dyspnea
- ☐ shallow
- ☐ diminished
- ☐ wheezing
- ☐ crackles
- ☐ pain
- ☐ orthopnea
- ☐ cough
- ☐ oxygen therapy
- ☐ intubated
- ☐ trach

Explain:

CARDIOVASCULAR
Assess: heart sounds, rate, rhythm, comfort

- ☐ NO PROBLEM
- ☐ tachycardia
- ☐ bradycardia
- ☐ irregular
- ☐ pace maker
- ☐ diminished pulse
- ☐ absent pulse
- ☐ edema
- ☐ palpitations
- ☐ pain in chest
- ☐ syncope
- ☐ fatigue
- ☐ numbness
- ☐ tingling

Explain:

NEURO
Assess: motor function, sensation, LOC, strength, grip, gait, coordination, orientation, speech, vision,

- ☐ NO PROBLEM
- ☐ lethargic
- ☐ confused
- ☐ stuporous
- ☐ comatose
- ☐ weakness
- ☐ unsteady
- ☐ paralysis
- ☐ seizures
- ☐ pain
- ☐ numbness
- ☐ tremors
- ☐ vertigo
- ☐ headache
- ☐ pupils
- ☐ visual abnormality
- ☐ grip
- ☐ speech
- ☐ tingling

Explain:

GI
Assess: abdomen, bowel habits, bowel sounds, comfort

- ☐ NO PROBLEM
- ☐ nausea/vomiting
- ☐ diarrhea
- ☐ distention
- ☐ hyperactive BS
- ☐ hypoactive BS
- ☐ pain
- ☐ mass
- ☐ rigidity
- ☐ anorexia
- ☐ constipation
- ☐ obese
- ☐ ostomy

Explain:

NUTRITION
Assess: diet, weight, swallowing, nutrition support,

Diet: ☐ Regular ☐ Other: _____

Food Allergies: ☐ None _____

_____

Adheres to Special Diet? ☐ Yes ☐ No

- ☐ Recent unplanned weight loss or appears malnourished?
- ☐ Persistent nausea/vomiting/diarrhea for > 3 days?
- ☐ Taking liquid nutritional supplements?
- ☐ Difficulty chewing/swallowing. Dysphagia?
- ☐ Has open wound?

- ☐ Referral made to Dietitian
- ☐ Patient does not desire intervention
- ☐ Patient terminally ill – comfort measures
- ☐ Patient followed by another Dietitian
- ☐ Patient followed by Physician for diet

GU/GYN
Assess: urine, frequency, control, color, bleeding, discharge, pregnancy, comfort

OB PTS:
*Gravida*_____ *Para* _____

- ☐ NO PROBLEM
- ☐ pregnancy
- ☐ contractions
- ☐ cramps
- ☐ low backache
- ☐ pelvic pressure
- ☐ discharge
- ☐ vaginal bleeding
- ☐ pain
- ☐ incontinence
- ☐ hesitancy
- ☐ frequency
- ☐ dysuria
- ☐ hematuria
- ☐ nocturia
- ☐ oliguria
- ☐ urostomy
- ☐ catheter
- ☐ dialysis

Explain:

MUSCULOSKELETAL
Assess: mobility, motion, gait, joint function

- ☐ NO PROBLEM
- ☐ assist devices
- ☐ balance
- ☐ transfers
- ☐ swelling
- ☐ atrophy
- ☐ eating
- ☐ bathing
- ☐ prosthesis
- ☐ stiffness
- ☐ pain
- ☐ deformity
- ☐ wound
- ☐ dressing

Explain:

In the past 3 months, how many times have you fallen?

How many of these falls caused an injury?

EENT
Assess: eyes, ears, nose, throat for abnormality

- ☐ NO PROBLEM
- ☐ impaired vision
- ☐ glasses
- ☐ blind
- ☐ hard of hearing
- ☐ hearing aid
- ☐ deaf
- ☐ gums
- ☐ teeth ☐ dentures
- ☐ pain
- ☐ reddened
- ☐ edema
- ☐ burning
- ☐ lesion
- ☐ drainage

Explain:

INTEGUMENTARY
Assess: color, temperature, turgor, integrity

Color:
- ☐ pink
- ☐ cyanotic
- ☐ mottled
- ☐ flushed
- ☐ pale
- ☐ jaundiced

Skin:
- ☐ warm
- ☐ dry
- ☐ cold
- ☐ diaphoretic

Turgor:
- ☐ normal
- ☐ other _____

Skin Integrity:
- ☐ intact
- ☐ impaired
- ☐ wound
- ☐ surgical incision

Explain:

PAIN ASSESSMENT

A. Do you have any ongoing pain problems? ☐ No ☐ Yes

Explain: _____

B. Do you have any pain now? ☐ No ☐ Yes

If yes to either A or B, indicate location of pain by marking diagram below

Pain Intensity Rating Scale Used: 0 = no pain 10 = worst possible

☐ Numerical 0-10 : _____

☐ Wong-Baker FACES

Description of pain sensation(burn, stab, prick, ache, sharp, dull, etc):

☐ **PCA Pt.**– Pain Assessment Flow Sheet initiated, Form INF-GEN022-1

What causes pain to get worse:

What pain medications and interventions do you use:

Are the interventions effective?

Are you ever pain free?

Does the pain affect your sleep?

Patient is unable to self-report:

☐ Facial expressions ☐ Vocalizations

☐ Physical movements ☐ No indicators present

Explain:

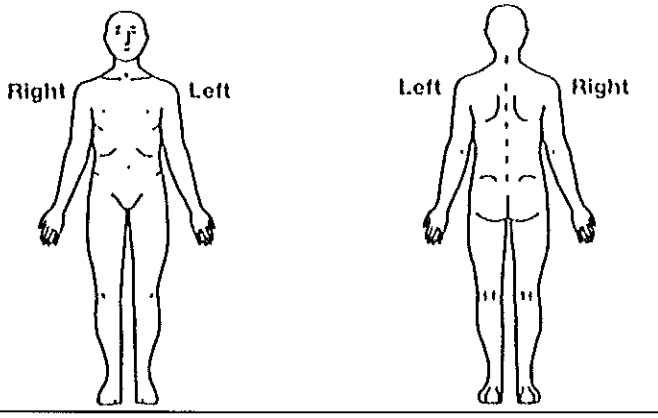
PSYCHOSOCIAL

Support Systems:	**Mental Status**	**Speech:**	**Spiritual/Cultural:** Is there anything from your culture or religion that we need to know in caring for you? ☐ No ☐ Yes
☐ Spouse/Significant Other	☐ Alert/Oriented	☐ Clear	
☐ Children: Number?:	☐ Participates in decision process	☐ Slurred	
☐ Friends	☐ Understands nature of condition	☐ Unresponsive	
☐ Neighbors	☐ Confused	☐ Non verbal	
☐ Meals on Wheels	☐ Unresponsive/comatose		If yes, explain:
☐	**Communication:**	**Emotional Status:**	
☐ **Agencies? Name/Services:**	☐ Not able to make needs known	☐ Effective coping skills	
	☐ Not able to answer simple questions	☐ Anxious/agitated	
	Any barriers to learning? ☐ No ☐ Yes	☐ Withdrawn/sad	
Caregiver:	Explain:	☐ Recent loss	
☐ Available, lives elsewhere		☐ Previous Psych. Hx.	
☐ Lives in residence			
☐ Available at all times	**Overall Status:** ☐ homebound ☐ bedbound	**Memory:**	
☐ Support systems adequate	☐ ambulatory ☐ non-ambulatory	☐ Memory intact	
☐ Lives alone	**ADL's:** ☐ Independent ☐ Dependent	☐ Loss of memory	
☐ Unsafe psychosocial climate	Able to continue to work? ☐ No ☐ Yes		

ENVIRONMENT/SAFETY

☐ Private home	☐ Adequate storage space	**Pets?** ☐ Yes ☐ No Type:
☐ Condo	☐ Adequate refrigeration	**Hygiene:** ☐ Good ☐ Fair ☐ Poor
☐ Apartment	☐ Adequate electrical outlets	Patient/caregiver able to comply with aseptic technique? ☐ No ☐ Yes
☐ Mobile home	☐ Working phone in home	
☐ Assisted living	☐ Phone available nearby	**Is there evidence of neglect by self or caregiver?** ☐ No ☐ Yes
☐ Safe neighborhood	☐ Running water available	If "Yes", explain:
☐ Unsafe neighborhood	☐ Safe/Adaptable for therapy	
Any interventions to make the environment safe?:		

DIAGRAM



B = Bruise

L = Laceration

D = Decubiti

R = Rash

S = Surgical Incision

W = Wound

P = Pain

C = Catheter Site

O = Ostomy Site

TEACHING/LEARNING

☐ Patient ☐ Caregiver:	PATIENT EDUCATION LEVEL:
☐ Are appropriate/able to learn and carry out procedures	☐ SPECIAL EDUCATION NEEDS: *DESCRIBE BELOW*
☐ Demonstrates adequate motivation to comply with plan	
☐ Verbalizes understanding of procedures taught	
☐ Comprehends responsibilities in the care process	
☐ Understands medical regime and possible complications	**Person to be taught Medication Administration:**
☐ Understands diagnosis / prognosis	☐ Patient
Comments:	☐ Caregiver Relationship?:
	Has experience in administering IV Therapy?: ☐ No ☐ Yes

SKILLED NURSING INTERVENTIONS

☐ **CATHETER/NEEDLE PRESENT ON ADMISSION:**

☐ Peripheral ☐ Central ☐ SubQ Needle
☐ Other: _____

Size/Type: _____

Location: _____ Lumens: _____

External Length: _____ cm

Inserted Where: _____ Date: _____

Site Assessment: _____

_____

_____

Blood Return? _____

Sutures/Clips Present: ☐ None

Number and Location: _____

Midarm Circumference 10 cm ↑ site _____ cm

☐ **CATHETER/NEEDLE REMOVED:**

☐ Per procedure

☐ Phlebitis 0 to +3 _____

☐ Infiltrated 0 to +3 _____

☐ **CATHETER/NEEDLE INSERTED BY RN AT VISIT:**

Size/Type: _____

Location: _____

Length: _____ No. of Attempts: _____

Midarm Circumference 10 cm ↑ site, if applies ___ cm

☐ **MEDICATION ADMINISTERED/CONNECTED AT VISIT:**

DRUG / FLUID: _____

_____

_____

_____

INFUSION METHOD: _____

DOSING SCHEDULE: _____

☐ NS IV: _____ ML's ☐ Heparin IV: _____ Units/ML _____ ML's

☐ EXT. Set Change ☐ Connector/Cap Change

☐ Dressing Change DSG. Type: ☐ Gauze ☐ Transparent

☐ OTHER: _____

☐ **BLOOD DRAW:**

Specify lab tests: _____

_____

Drawn From: ☐ Catheter ☐ Venipuncture

Venipuncture Site: _____

Taken To: _____ Lab

Evaluation of peripheral venous access: ☐ Good ☐ Fair ☐ Poor

****Arm not to be used for venous access:** ☐ Left ☐ Right

Reason: _____

Previous History of IV Therapy?: _____

_____

SUMMARY

Conclusions on patient's ability to reach goals and patient's expectations of therapy:

Next scheduled appointment with ordering physician: **Next RN visit:**

Patient Signature: _____ **Nurse Signature:** _____ **Date:** _____

Personal Representative Signature: _____ **Relationship:** _____

Name of Dispensing Pharmacy: _____

IV Flow Sheet

bioscrip® Infusioncare

Form CLIN-NUR207-1

Patient Name: _____ Date: _____

Height _____ Weight: _____lb _____ kg Allergies: _____

Premeds given: ☐ N/A

TIME PRE-MEDS Given: _____

□ 25 mg Diphenhydramine □ PO □ IV
□ 50 mg Diphenhydramine □ PO □ IV
□ 650 mg AcetaminophenTylenol PO

□ Other: _____

Medication: _____
Dose: _____ grams in _____ ml of _____ to infuse
for _____ hours via _____.

Lot Number: _____ Expiration Date: _____
Lot Number: _____ Expiration Date: _____
Lot Number: _____ Expiration Date: _____

Administration and patient monitoring
For IVIG (pre-infusion, every 15 minutes for the first hour, hourly during infusion, and post infusion)

Time	Temp	Pulse	Resp	BP	Rate, as □ ml/hr □ gtts/min	IV Patent	S/S adverse reaction	Comments
						□Y □N	□Y □N	**Pre-Infusion**
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	
						□Y □N	□Y □N	

Clinical Notes: _____

_____

_____

_____

Clinician Signature: _____ Date: _____

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INFUSION PATIENT TEACHING CHECKLIST

Form INF-GEN023-1

PATIENT NAME: (last, first) | Date of Birth:

THERAPY: ☐ Anti-infective ☐ Antiemetic ☐ Biological ☐ Chemo ☐ Diuretic ☐ TPN ☐ Hydration ☐ Immunotherapy ☐ Line Maintenance ☐ Pain ☐ Steroid

Other:_____ Drug:_____

Infusion Method:

☐ Pump (NAME): _____

☐ Elastomeric Device ☐ Gravity ☐ IV Push ☐ Other:_____

Access Device:

❑ Subcutaneous ❑ PICC
❑ Peripheral ❑ Central Catheter
❑ Midline ❑ Implanted Port
❑ Other: _____

Date/Initial Demonstrated By	Date/Initial Independent With	***Introduction:***
		❑ Customer Orientation Booklet
		❑ Disease Process/reporting changes
		❑ Physician's Orders
		❑ Therapy risks and benefits
		❑ Patient/Caregiver Participation
		❑ Identifying treatment goals
		❑ Plan of Care
		❑ Written Patient Education Materials
		❑ Importance of compliance
		❑ Drug Monograph/Medication Guide
		❑ Coping Strategies (Resources)
		❑ RN Visit Schedule
		Safety/Infection Control
		❑ Hand Washing
		❑ Work Area Preparation
		❑ Clean & Sterile Procedures
		❑ Standard Precautions
		❑ Waste Disposal
		❑ Sharps Disposal Instructions
		❑ Chemo Precautions/Using Spill Kit
		Meds and Supplies
		❑ Reporting medication changes
		❑ Store/Order/Delivery Schedule
		❑ Checking the drug and label
		❑ Preparing and adding drugs
		❑ Dosing Schedule
		Self-monitoring
		❑ Drug toxicities reporting
		❑ Temperature
		❑ Weight
		❑ Measuring Intake & Output
		❑ Monitoring Blood Sugar
		❑ Recordkeeping
		Other Procedures
		❑
		❑

Date/Initial Demonstrated By	Date/Initial Independent With	***Access Device Care***
		❑ Device Name/Type
		❑ Site Inspection & Care
		❑ Dressing Change
		❑ Flushing All Lumens
		❑ Flushing Frequency/ Amount
		❑ Changing Connector or Cap
		❑ Clamp usage
		❑ Device Removal
		❑ Activity Restrictions/Bathing
		Possible Complications
		❑ Signs of an Allergic Reaction
		❑ Drug Adverse Reactions
		❑ Catheter Blockage
		❑ Catheter Damage/No scissors
		❑ Catheter Leakage
		❑ Catheter related Infection
		❑ Septicemia
		❑ Phlebitis
		❑ Infiltration/extravasation
		❑ Blood Backup
		❑ Air Embolism
		❑ Speed Shock
		Administration Procedures
		❑ Gravity Infusion
		❑ Electronic Pump
		• operation/maintenance
		• alarm system
		• change or charge battery
		• troubleshooting
		❑ Connection Procedures
		❑ Disconnection Procedures
		❑ Setting the Rate
		❑ Changing/Priming IV Tubing
		❑ Changing the Cassette/Bag
		❑ IV Push
		❑ Sub Q Injection or Infusion

I fully understand that I am responsible for complying with the regimen prescribed by my physician, and hereby release the physician and COMPANY from any liability connected therewith, or any complication of treatment failure that may result from my non-compliance.

Patient Signature :_____ **Nurse Signature :**_____ **Date :**_____

Personal Represntaive Signature :_____ Relationship :_____

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

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

ROYAL QUALITY NURSING SERVICES, INC.

PATIENT: _____ DIAGNOSIS: _____

NURSING CARE PLAN

Patient Problem (Check all that apply)	Nursing Intervention (Check all that apply)	Desired Outcomes/End Goals (Check all that apply)
1. Identified by _____ RN Date: _____ ___ Knowledge deficit as related to the purpose, indications, management of home therapy: (Circle one) ABT ST IVIG HYD LAB CC Other: _____	_Nurse will provide patient/caregiver education by explanation, discussion, demonstration and handouts.	Patient/Caregiver will be able to: _ Verbalize understanding of purpose and goals of prescribed therapy/treatment _Verbalize understanding of complications/problems and their interventions Independent Administration of prescribed regimen: _ SASH _ Saline Only _ Heparin Only _Safely operate device: (Specify) _____ _____
2. Identified by _____ RN Date: _____ _ Potential for complications related to non-compliance	_ Nurse will review with patient/caregiver the prescribed regimen.	Patient/Caregiver will be compliant with prescribed therapy evidenced by: _ Desired outcomes. _ Progression to goals.
3. Identified by _____ RN Date: _____ _ Potential for Adverse Drug Reactions	_ Nurse will review with patient/caregiver possible signs/symptoms of adverse reactions related to the prescribed drug regimen.	Patient/Caregiver will be able to: _ Verbalize understanding of possible signs/symptoms of adverse reactions
4. Identified by _____ RN Date: _____ _ Alteration in comfort (pain) related to (Specify) _____	_ Nurse will assess patient's pain each visit. _ Nurse will review patient's prescribed pain control regimen	Patient will obtain optimal level of comfort evidence by: _ Verbalizing pain free. _Verbalizing improvement of pain (pain at a manageable level)
5. Identified by _____ RN Date: _____ _ Fluid Volume Excess/Deficit	Nurse will monitor: _ Vital Signs (Orthostatic BP necessary for all patients receiving hydration.) _ Weight _ Intake & Output _ Electrolytes	Patient will maintain fluid volume balance evidenced by: _ Normal Vital Signs _ Adequate urinary output _ Normal Electrolyte levels

ROYAL QUALITY NURSING SERVICES, INC.

PATIENT: _____ DIAGNOSIS: _____

NURSING CARE PLAN

6. Identified by _____ RN Date: _____ _ Alteration in nutrition less than body requirements related to inadequate nutrient intake/disease process.	_ Nurse will provide patient education by explanation, discussion, demonstration and handouts. Nurse will monitor: _ Vital Signs _ Weight _ Intake & Output _ Electrolytes	Patient will achieve and maintain acceptable level of nutrition as evidenced by: _ Weight gain/loss _ Maintenance of acceptable nutritional parameters including ordered laboratory test/values.
7. Identified by _____ RN Date: _____ _ Potential for infection Access site: PICC Periph. Port Hickman/Groshong	_ Nurse will assess access site as prescribed by MD _ Nurse will review with patient/caregiver: signs and symptoms of infection	Patient will remain infection free as evidenced by: _Normal temperature: < 100 F _ No redness, pain or drainage at access site
8. Identified by _____ RN Date: _____		
9. Identified by _____ RN Date: _____		

Reviewed Date: _____ by _____ RN
Reviewed Date: _____ by _____ RN

I have had an opportunity to discuss my care and treatment in the development of this plan of care and approve of the care prescribed.
Patient/Caregiver _____
Initiated by _____

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Form CLIN-GEN019-1

Medication Profile

Patient: _____ Patient ID: _____

Date: _____ Allergies: _____

Height: _____ Weight: _____ Age: _____

Other Pharmacy: _____ Other Pharmacy Phone Number: _____

Start Date	Stop Date	Medication Name	Dosage	RT. CD.	Freq. Code	New/ Chg.	Physician	Init.	Comments
		Heparin							
		0.9% NaCl							

Route Code			
EN	Ear/Nose	TO	Topical
IM	Intramuscular	NG	Nasogastric
OP	Ophthalmic	IC	Intravenous Central
PO	Oral	IP	Intravenous Peripheral
IN	Inhale	PR	Per Rectum
VG	Vaginal	ET	Enterostomal Tube
SubQ	Subcutaneous	IVP	IV Push

Frequency Code			
Q2H	Every Two Hours	BID	Twice A Day
Q3H	Every Three Hours	QAM	Every AM
Q4H	Every Four Hours	QPM	Every PM
QID	Four Times A Day	Must write out	Every Other Day
TID	Three Times A Day		

Unit	Amount of Measurement
GM	Gram
GR	Grain
ML	Milliliter
OZ	Ounce
CM	Centimeter

Initials:____ Signature:_____ Initials:____ Signature:_____

Initials:____ Signature:_____ Initials:____ Signature:_____