option care™

60 Day Summary Alt

Patient Name: _____ **DOB:** _____ **Date:** _____

Patient MRN: _____ **Admit Date:** _____ **Re-Admit Date:** _____

Services provided in last 60 Days: ☐ **Home Visit** ☐ **Phone Follow-up** ☐ **Hospital Visit** ☐ **M.D. Office Visit**

☐ **Supply Delivery** ☐ **Other:** _____

Prescriber Name: _____

Current Infusion Prescription: _____

Premedications: _____

Current Medication Profile Reviewed: ☐ YES ☐ NO ☐ NO CHANGE

Temperature range: _____

Heart Rate Range: _____

B/P Range: _____

Current weight: _____ ☐ + ☐ - since last infusion: _____

Wound condition/measurements: _____

Access device: _____

Any side effects noted: _____

Pathway reviewed and updated: _____

MD orders reviewed and updated: _____

Frequency of care: _____

Labs drawn: _____

Assessment: _____

_____

Patient/Caregiver teaching: _____ **Plan:** _____

☐ Needs reinforcement: _____ ☐ Therapy adjustment/change: _____

☐ Independent: _____ ☐ Nutrition assessment: _____

☐ Dependent on nursing for administration: _____ ☐ Continue teaching: _____

☐ Other: _____ ☐ Continue therapy: _____

Clinician Name: _____ **Clinician Signature:** _____

Physicians Name: _____ **Physician Phone:** _____ **Physician FAX Number:** _____

(For office use only): Date mailed / faxed to MD: _____