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Patient Assessment Form - Adult

☐ Start of Care ☐ Recertification ☐ Homebound Visit Type: ☐ Home ☐ ATS ☐ PRN ☐ **Patient ID Verified**

Patient Name:	MRN	Age	DOB	Sex ☐ M ☐ F	Date

Source of Information: ☐ Patient ☐ Other:

Reason for Homecare – Primary Diagnosis & Current Home Infusion Medications:

Other Pertinent History and Surgeries: | Primary Language:

Religious/Cultural Practices: | Social/Community Involvement: | Occupation:

Immunizations: ☐ Up-to-date ☐ Other:

Social / Environmental History

Living Situation:
☐ House
☐ Mobile Home
☐ Apartment
☐ Nursing Home
☐ Hotel suite / Efficiency
☐ Other: _____

Marital Status:
☐ Single ☐ Domestic Partner
☐ Married ☐ Widow(er)
☐ Other people living in home:
_____
_____
_____

Home Environment Safety

Suitable for Care: ☐ Yes ☐ No (See Skilled Intervention Note)
☐ Scattered Rugs ☐ Cluttered Living Space/Stairs
☐ Infestation ☐ Unsafe Bathroom
☐ No Smoke Detectors ☐ No Fire Extinguisher
☐ Oxygen used ☐ Unsafe Entry or Exits
☐ No Telephone ☐ Improper Storage of Hazardous Material
Inadequate: ☐ Air ☐ Heat ☐ Plumbing ☐ Electrical ☐ Refrigeration
Comments: _____

Vital Signs

WT Actual:	WT Stated:	**Temp:** _____ ☐ PO ☐ Ax ☐ Other: _____	**Resp:**	**Heart Rate:**	**B/P:** _____ ☐ RA ☐ LA ☐ Sitting ☐ Lying ☐ Standing

***NPA = No Problem Assessed** — **Systems Review**

Endocrine

☐ NPA
☐ Diabetes – Type: _____
☐ Current FSBS: _____
☐ Thyroid Disorder: _____
☐ Adrenal Disorder: _____
_____
Pregnant: ☐ Yes ☐ No
☐ Other: _____
_____
_____

Genitourinary

☐ NPA ☐ Urgency
☐ Frequency ☐ Retention
☐ Incontinence ☐ Dysuria
☐ Hematuria # wet diapers/day: _____
☐ Other: _____
☐ Catheter: ☐ Indwelling ☐ Intermittent
☐ External Date Placed: _____
Comments: _____
_____
_____

Cardiovascular

☐ NPA ☐ Cap Refill>3 secs ☐ Abnormal Heart Rhythm
☐ Palpitations ☐ Neck Vein Disten. ☐ Abnormal Hearts Sounds
☐ Tachycardia ☐ Hypertension ☐ Edema
☐ Bradycardia ☐ Hypotension ☐ Pitting: ☐ +1 ☐ +2 ☐ +3 ☐ +4
☐ Angina ☐ Pacemaker Location: _____
☐ Defibrillator ☐ Other: _____

Peripheral Pulses:
RUE: ☐ Present ☐ Absent **RLE:** ☐ Present ☐ Absent: Location: _____
LUE: ☐ Present ☐ Absent **LLE:** ☐ Present ☐ Absent: Location: _____
Comments: _____

Psychosocial

☐ NPA
☐ Alert
☐ Lethargic
☐ Unresponsive
☐ Flat Affect
☐ Agitated
☐ Anxious
☐ Confused

Communication Issues:
☐ NPA
☐ Vision: _____
☐ Hearing: _____
☐ Language/Literacy
☐ Aids Used/Needed: _____
_____
Comments: _____
_____

Speech:
☐ NPA ☐ Slurred
☐ Garbled ☐ Aphasic

Memory:
☐ Good ☐ Fair ☐ Poor

Oriented to:
☐ Person ☐ Place ☐ Time

Comments: _____
_____

Neuromuscular

☐ NPA ☐ Vertigo
☐ Headache ☐ Spasticity
☐ Paresis ☐ Flaccidity
☐ Tremors ☐ ROM Loss
☐ Ataxia ☐ Contractures
☐ Alt. Level of Consciousness (describe):
_____
☐ Paralysis – Level: _____
☐ Seizures (describe): _____
_____
☐ Numbness ☐ CVA ☐ Shunt
☐ Joint Swelling ☐ Joint Stiffness
☐ Other: _____
_____
☐ Sensory Alterations:
☐ Smell ☐ Touch ☐ Taste
Comments: _____
_____

Respiratory

☐ NPA ☐ Orthopnea:
☐ Diminished # pillows _____
☐ Wheezes ☐ Tachypnea
☐ Rhonchi ☐ Stridor
☐ Crackles: ☐ Course ☐ Fine
☐ Dyspnea:
☐ On Exertion ☐ At Rest
☐ Cough:
☐ Productive ☐ Non-Prod.
☐ Sputum (describe): _____
☐ Other: _____
_____
☐ O_2 at: _____ LPM: _____
☐ Continuous ☐ Intermittent
☐ N/C ☐ Mask
DME Co.: _____
_____
Comment: _____
_____

GI/Nutrition

☐ NPA ☐ Abdomen:
☐ Nausea ☐ Vomiting ☐ Taut
☐ Dysphagia ☐ Distended
☐ Constipation ☐ Ascites
☐ Diarrhea ☐ Masses
☐ Bleeding ☐ Tenderness
☐ Ostomy: _____ ☐ ABD Girth:
Last BM: _____ _____
Bowel Sounds: ☐ Present ☐ Absent
☐ Recent Change in Bowel Habits
Diet: _____
Appetite: ☐ Good ☐ Fair ☐ Poor
☐ Enteral Tube Type: _____
☐ Formula: _____
☐ Intermittent: _____
☐ Continuous: _____
☐ Wt Gain/Loss: _____ lbs
Comments: _____

Integumentary

☐ NPA ☐ Dry ☐ Diaphoretic ☐ Pale ☐ Turgor Poor ☐ Rash ☐ Pruritus ☐ Petechiae ☐ Jaundice ☐ Birthmark
☐ Bruises ☐ Abrasion ☐ Incision ☐ Staples ☐ Sutures ☐ Laceration ☐ Pressure Ulcer ☐ Burns
☐ Patient/Caregiver Independent with Wound Care ☐ Wound Managed by: ☐ Wound Clinic ☐ MD Office
☐ Other HHA: _____
☐ SN Performing Wound Care/Assessment (see Wound Addendum) ☐ SN treating active Bleed (see Bleeding Disorder Addendum)
Comments: _____

White - Medical Records Yellow - Patient

Patient Assessment Form - Adult (cont.)

Patient Name: _____ **MRN:** _____

Pain

☐ NPA Current Pain Level (0 - 10): _____ Location: _____ Acceptable Pain Level (0 - 10): _____
Pain Description: _____
Relief Measures: _____ Pain Controlled? ☐ Yes ☐ No*
*Intervention: _____

Access Device

Access: ☐ N/A
☐ Peripheral IV start - Attempts x _____ ☐ Peripheral line in place Gauge: _____ Length: _____ Date/Location: _____

☐ PICC or ☐ Midline Site: _____ Type: _____ Lumens: _____
Ext. catheter length: _____cm ☐ Arm Circumference: _____ cm Measurement: 4cm or _____cm above insertion site.
☐ CVAD Site: _____ Type: _____ Lumens: _____ ☐ Tunneled ☐ Non-tunneled
☐ Accessed Port this SNV ☐ Port access in place: Non-coring needle size: _____ gauge _____ inch ☐ Port de-accessed
☐ Subcutaneous ☐ NGT / GT / JT Location: _____ Type: _____ ☐ Other: _____
Access site clean/dry & free of s/sx infection ☐ Yes ☐ No – Describe: _____
☐ Access discontinued – Reason: ☐ Site rotation ☐ Infiltration ☐ Erythema ☐ Leak ☐ Occlusion ☐ Thrombosis ☐ Infusion complete
☐ Therapy concluded ☐ Prescriber order Comments: _____
Dressing / Flush: Access Dressing Change: ☐ N/A ☐ Access flush pre/post med: _____ ml of ☐ NS ☐ D5W
Access flush pre/post lab: ☐ _____ ml NS ☐ Access flush for maintenance: ☐ NS _____ ml ☐ Heparin: _____ ml
Antiseptic Agent: ☐ 3 Alcohol ☐ 3 Betadine ☐ ChloraPrep ☐ Other: _____
Dressing: ☐ Transparent ☐ Gauze & tape ☐ Other: _____ ☐ Antibacterial dressing changed
☐ Securement device changed ☐ Needleless connector changed x _____ Lumens ☐ Extension tubing changed x _____ Lumens
Lab Work: ☐ N/A ☐ BMP ☐ CMP ☐ Pro-time ☐ ESR ☐ Trough ☐ Peak ☐ CBC ☐ Other: _____
Specimen obtained from: ☐ Peripheral Venipuncture ☐ Venous Access Device _____ ml blood discarded
Specimen delivered to: _____

INFUSION RECORD ☐ N/A

☐ **Rx Properly Stored** ☐ **Anaphylaxis Kit Expiration:** _____ ☐ **N/A**
Medication: _____ **Dose:** _____ **Volume:** _____
Medication: _____ **Dose:** _____ **Volume:** _____
Method of administration: ☐ **IVP** ☐ **INJ** ☐ **Gravity-Flow Controlled** ☐ **Pump** ☐ **Disp. Pump** ☐ **Other:** _____
Pump Program #1: _____ **Pump Program #2:** _____
Factor: Lot #: _____ **Exp. Date:** _____ **Labeling checked with orders: SN initial** _____
☐ **Pre-medication (dose & time):** _____

TIME	TEMP	PULSE	RESP.	B/P	RATE	(Patient status / condition / comments)

☐ **Inventory completed:** ☐ **Adequate supplies** ☐ **Ordering** ☐ **Medication Profile Reviewed: No Changes**
☐ **Discharge Plan discussed with patient/caregiver.** **Plan for next visit:** _____

Communication with: ☐ MD ☐ RPh ☐ Other: _____

Skilled Intervention Note: _____

Patient Visit Time: *Start:* _____ *End:* _____ **Lab Time:** *Start:* _____ *End:* _____ **Total Time:** _____

Nurse's Signature **Patient's Signature** **Date**

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Infusion Vital Sign Flow Record

Patient Name: _____ **MRN:** _____ **Access Type:** _____

Medication: _____ **Dose:** _____ **Volume:** _____

☐ Medication label(s) checked with order. **Pre-Medications (dose & time):** _____

_____

Time	Temp	Pulse	Resp.	B/P ☐ S ☐ ST ☐ L	Rate (ml/hr)	Patient Response / Comments

_____ / _____

Clinician Printed Name Clinician Signature Date

_____ / _____

Clinician Printed Name Clinician Signature Date

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Patient Education Checklist

Check all applicable content

Enter service date(s) into columns as appropriate

Patient Name: _____

MRN: _____ SOC Date: _____

CONTENT	CONTENT DISCUSSED / REVIEWED	ASSISTED RETURN DEMONSTRATION	INDEPENDENT RETURN DEMONSTRATION
☐ **Patient Admission Documents Given/Reviewed:** ☐ Consents ☐ "Getting started with infusion therapy" Booklet ☐ Admission Agreement/Acknowledgement of Receipt of Information ☐ Accreditation information ☐ Home Health Agency state required information (☐ N/A) ☐ Agency 24 Hour Contact #: _____ ☐ Other: _____			
☐ **Review of Disease Process** ☐ **Compliance Needs** ☐ **Patient Education Handouts Given & Reviewed:** ☐ Drug Monograph ☐ Medication Guide ☐ Access Device: _____ ☐ Pump Manual: _____ ☐ IV Access (as needed for IV insertion training) ☐ Other: _____			
Drug / Solution: _____ Label Accuracy: ☐ Correct Patient Name ☐ Correct Drug ☐ Dose: _____ ☐ Schedule: _____ ☐ Container Integrity ☐ Inspection of Drug/Solution Storage: ☐ Refrigeration ☐ Room Temp ☐ Protect from light			
Infection Prevention: ☐ Hand Washing ☐ Aseptic Technique ☐ Work Surface Preparation ☐ Device Access / De-access ☐ Blood & Body Fluid Precautions Prepping: ☐ Injection Site(s) ☐ Connectors ☐ Tubing ☐ Needles			
Infusion Access Device Management: ☐ Type / Access: _____ ☐ Clamping ☐ Site Inspection ☐ Patency Check ☐ Flushing ☐ Bathing ☐ Site Care/Dressing Change ☐ Connector/ Extension Change ☐ PIV Insertion / Removal ☐ Other: _____			
Drug / Solution Preparation: ☐ Premixed ☐ Reconstitution/Transfer ☐ Additives: _____ ☐ Medication-Solution Set-Up ☐ Other: _____			
Administration Method: ☐ IV Push ☐ Gravity ☐ Rate-Flow Controlled Tubing ☐ Disposable Elastomeric ☐ Pump: _____ ☐ Continuous ☐ Intermittent ☐ Cycle/Taper Injection: ☐ Intramuscular ☐ Subcutaneous			
Administration Technique: ☐ Tubing Calibration ☐ Pump Programming ☐ Loading Pump ☐ Filter ☐ Priming Tubing ☐ Batteries ☐ Alarms ☐ Troubleshooting Access Device: ☐ Connect ☐ Disconnect ☐ Other: _____			

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Patient Name: _____ MRN: _____

Potential Complications - Prevention & Intervention: ☐ Infection: ☐ Exit/Injection Site ☐ Systemic ☐ Blood Reflux ☐ Occlusion ☐ Phlebitis ☐ Infiltration ☐ Migration ☐ Break ☐ Thrombus/Embolus ☐ F/E Imbalance ☐ Hyper-Hypoglycemia ☐ Metabolic ☐ Aspiration (oral/enteral) ☐ Nausea/Vomiting ☐ Diarrhea ☐ Adverse Reactions ☐ Anaphylaxis ☐ Hypersensitivity Reaction ☐ Using Epinephrine Autoinjector			
Supplies - Handling / Disposal / Inventory: ☐ Sharps Container ☐ Regular Waste ☐ Narcotics ☐ Hazardous Material ☐ Chemo Precautions ☐ Supply Inventory ☐ Deliveries ☐ Pump Return☐ Other Resources: _____			
Safety: ☐ 911 / EMS ☐ Electrical / Fire ☐ Falls ☐ Travel & Supplies ☐ Other: _____			
Ongoing Monitoring: ☐ Weight: _____ ☐ I&O: _____ ☐ Temp: _____ ☐ Blood Glucose: _____ ☐ Lab Draws: _____ ☐ Appointments: _____ ☐ Other: _____			

Additional Instructions / Comments: _____

Date	Nurse Signature	Date	Nurse Signature

I have received the above information and understand that I will be learning about my disease process, therapy and treatment using the information in the materials that were given to me.

Patient Signature _____ Date _____

Caregiver Signature (if applicable) _____ Date _____ Caregiver Relationship to Patient _____

Release of Direct Supervision: I understand that I am now able to perform all of the above listed activities and no longer need the direct supervision of a nurse or pharmacist. I also understand that these skills will be checked by the nurse or pharmacist when needed.

Patient Signature _____ Date _____

Caregiver Signature (if applicable) _____ Date _____ Caregiver Relationship to Patient _____

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ORDER

Plan of Treatment

Certification Period ______________ to ______________

Patient Demographics

Patient Name:	MRN	Age	DOB	Gender ☐ M ☐ F	SOC Date
Address:	City, State, Zip				Phone:

Diagnosis			
Diagnosis	Primary Diagnosis:	ICD-10 Code:	Onset Date
	Secondary Diagnosis:	ICD-10 Code:	Onset Date
	Additional Diagnosis:	ICD-10 Code:	Onset Date

Allergies (allergen and reaction):

Code Status (select from the following as applicable):
☐ Full code ☐ Do Not Resuscitate
☐ Advance Directive ☐ Copy on file ☐ Copy Requested

Prognosis:
☐ Excellent ☐ Good ☐ Fair
☐ Guarded ☐ Poor ☐ Other: ______

Rehab Potential:
☐ Full Recovery
☐ Partial Recovery
☐ No Recovery
☐ Terminal
☐ Palliative Care

Functional Limitations:
☐ No Deficiency ☐ Contractures ☐ Mental/Cog
☐ Endurance ☐ Paralysis ☐ Vision
☐ Ambulation ☐ Amputation ☐ Speech
☐ Dyspnea with minimal exertion ☐ Hearing
☐ Bowel / Bladder Incontinence ☐ Other: ______

Mental Status:
☐ Alert/Oriented ☐ Anxious
☐ Confused ☐ Lethargic
☐ Depressed ☐ Comatose
☐ Spiritual Needs Unmet
☐ Other: ______

Activities:
☐ No Restrictions ☐ Independent at Home
☐ Home Bound ☐ Bed Bound
☐ Non-Ambulatory ☐ Ambulatory
☐ Complete Bed Rest ☐ BRP ☐ Up as Tolerated
☐ Transfer Bed/Chair ☐ Exercise Prescribed
☐ Partial Weight Bearing: ☐ L ☐ R
☐ Cane ☐ Walker ☐ Crutches ☐ Wheelchair
☐ Other: ______

Safety Measures:
☐ 911 / EMS Protocol ☐ Med storage
☐ Standard Prec. ☐ Oxygen
☐ Hazardous Waste Disposal
☐ Electrical ☐ Emergency Disaster

Diet:
☐ Regular
☐ ADA ______
☐ Cardiac ______
☐ Other: ______

DME/Supplies:
☐ Infusion Pump ☐ Sharps Container
☐ Infusion Pole
☐ Infusion Supplies ☐ Other: ______

Nursing Intervention/Orders

SN Assess With Each Patient Visit:
☐ Physical Assessment ☐ Compliance with orders
☐ Response to Therapy ☐ Safe home environment
☐ Cognitive/Functional limitations ☐ Level of pain
☐ Instruction Needs ☐ Other: ______

SN Visit Frequency: ______
with ____ p.r.n. visits for: ______

☐ **SN to administer** ☐ **Teach patient/caregiver administration of prescribed therapy: (list medication, dose, frequency, titration)**

☐ ______
via: ☐ PIV ☐ MID ☐ PICC ☐ Central Line ☐ Implanted Port ☐ Subcutaneous ☐ NGT / GT / JT ☐ Other: ______
Method of administration: ☐ IVP ☐ INJ ☐ Gravity-Flow Controlled ☐ Pump ☐ Disp. Pump ☐ Other: ______

☐ ______
via: ☐ PIV ☐ MID ☐ PICC ☐ Central Line ☐ Implanted Port ☐ Subcutaneous ☐ NGT / GT / JT ☐ Other: ______
Method of administration: ☐ IVP ☐ INJ ☐ Gravity-Flow Controlled ☐ Pump ☐ Disp. Pump ☐ Other: ______

☐ ______
via: ☐ PIV ☐ MID ☐ PICC ☐ Central Line ☐ Implanted Port ☐ Subcutaneous ☐ NGT / GT / JT ☐ Other: ______
Method of administration: ☐ IVP ☐ INJ ☐ Gravity-Flow Controlled ☐ Pump ☐ Disp. Pump ☐ Other: ______

☐ Kalbitor three 10 mg doses (30 mg total) subcutaneously PRN for acute attacks of hereditary angioedema (HAE). If no response in 45 - 60 minutes, contact the physician before administering a second dose.

☐ Kalbitor three times 10 mg doses (30 mg total) subcutaneously PRN for acute attacks of HAE. If no response in 45 - 60 minutes, administer a second 30mg dose. If no response in 45 - 60 minutes after second dose, contact the physician.

☐ SN to titrate IVIG as using following steps: 1.____ ml/hr x ____ min; 2. ____ ml/hr x ____ min; 3.____ ml/hr x ____ min; 4.____ ml/hr x ____ min; 5.____ ml/hr x ____ min; 6.____ ml/hr x ____ min; followed by maximum rate of ____ ml/hr for remainder of infusion.
Titration shall be dependent on patient's tolerance. Other: ______

☐ SN to monitor for hypersensitivity a minimum of 1 hour post medication administration for first dose and Kalbitor.

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ORDER

Plan of Treatment (cont.)

Patient Name: _____ **MRN:** _____

Nursing Intervention/Orders (continued)

☐ Pediatric: ☐ NS ☐ D5W flush pre/post infusion and p.r.n. ☐ 1 - 3 ml PIV/Midline/CVC/PICC/Port/valved catheter ☐ 1 - 5 ml pre/post lab
☐ Adult: ☐ NS ☐ D5W flush pre/post infusion and p.r.n.: ☐ 2 - 3 ml PIV ☐ 3 - 5 ml Midline/CVC/PICC/ ☐ 5 - 10 ml Port / valved catheter
☐ 5 - 10 ml pre/post lab Midline/CVC/PICC ☐ 10 - 20 ml pre/post lab Port / valved catheter
☐ Other flush protocol: _____
☐ Pediatric: Heparin IV_____ units/ml post infusion and p.r.n.: ☐ 0.5 - 3 ml PIV/Midline/CVC/PICC ☐ 0.5 - 5 ml Port
☐ Adult: Heparin IV_____ units/ml post infusion and p.r.n.: ☐ 1 - 3 ml PIV/Midline ☐ 3 - 5 ml CVC/PICC/Port
☐ Enteral flush: _____
☐ **See attached Medication Profile for additional medications.** ☐ **No Additional OTC Medications or Herbal/Home Remedies**
☐ SN to establish Peripheral IV access. Change PIV access every _____ days ☐ With each dose ☐ PRN
☐ SN may: ☐ Administer Lidocaine 1% 0.1 ml intradermal ☐ Apply Topical anesthetic _____ per manufactures guidelines for IV insertion p.r.n.
☐ SN to remove ☐ Teach patient/caregiver removal of: PIV at completion of IV therapy.
☐ SN to remove ☐ PICC ☐ Non-tunneled CVC: when therapy complete.
☐ SN to perform central line care: Cleanse site with alcohol x3, betadine x3, or chloraprep swab, and apply TSM dressing weekly and p.r.n. loss of integrity; may apply antimicrobial dressing to IV site p.r.n. inflammation/prophylaxis (or) site care per _____ protocols.
☐ SN to perform ☐ Teach patient/caregiver to access/deaccess: implanted port. Non-coring needle change: ☐ Weekly ☐ Other: _____
☐ CVC/PICC occlusion orders: Declot catheter p.r.n. with _____ following drug manufacturer instructions for use.
☐ SN to administer ☐ Teach patient/caregiver to administer: subcutaneous injections, site rotation and signs/symptoms of complications to report.
☐ SN to administer Anaphylaxis/Adverse Drug Reaction Kit p.r.n. per protocol. ☐ SN to teach patient/caregiver administration of epinephrine autoinjector p.r.n. signs and symptoms of anaphylaxis.
☐ SN to obtain lab specimen(s) as ordered: _____
☐ Labs beginning week of: _____ ☐ May draw labs from CVC if appropriate.
☐ SN to administer and teach patient/caregiver to administer enteral therapy using **bolus / gravity / pump; NGT / GT / JT** management and signs and symptoms to report.
☐ SN to monitor, teach patient/caregiver to monitor blood glucose as instructed. Test blood glucose pre infusion & 2 - 4 hrs into infusion. Goal: 80 - 140 mg/dl. If FSBS > 180 mg/dl, notify pharmacist during normal business hours. If FSBS is < 60 or > 300 mg/dl, notify pharmacist immediately. ☐ Other orders: _____
☐ SN to monitor, teach patient/caregiver to monitor for signs & symptoms of hyper/hypoglycemia and to report findings to pharmacy / physician as instructed.
☐ Patient is independent with: ☐ Diabetic management ☐ Other: _____
☐ Patient's _____ is controlled with current therapy; SN to reinforce care, signs and symptoms of complications p.r.n.

Additional Orders/Recertification Summary: _____

Goals

☐ Patient/Caregiver will demonstrate safe administration of Rx therapy. Will achieve ☐ Partial ☐ Complete independence in therapy as applicable.
☐ Patient/Caregiver will verbalize potential side effects and/or complications of therapy to report and appropriate action as required.
☐ Patient/Caregiver will demonstrate correct care and maintenance of access device: ☐ IV ☐ Enteral ☐ Subcutaneous ☐ Other: _____
☐ Infusion access device will remain free from infection or other complications. ☐ Resolve/Improve infection(s): _____
☐ Therapy will be tolerated without adverse event ☐ Patient will maintain/improve activity level ☐ Patient will demonstrate improved mobility.
☐ Nutritional status ☐ Fluid/electrolyte balance will be maintained/improved as evidenced by labs WNL, weight stabilization and/or improved clinical condition. ☐ Patient's HAE symptoms shall be adequately controlled with adverse reaction prevented or recognized and minimized.
☐ Patient's pain level, on a scale of 0 - 10, will be at an acceptable level to the patient of: _____
☐ Other: _____

Discharge Plans

☐ Discharge patient from home health services when goals are met and/or therapy completed.
☐ Discharge to care of family member or caregiver with MD follow-up.
☐ Discharge to self-care with MD follow-up when independent in self-therapy. ☐ Other: _____
Plan of Treatment reviewed with ☐ Patient ☐ Caregiver ☐ RPh: _____

Nurse Signature: _____ **Date:** _____

I ☐ CERTIFY/ ☐ RECERTIFY that the above home health services are required and authorized by me. This client is under my care and is in need of skilled nursing and/or therapeutic services. I will periodically review the written plan of treatment in accordance with Option Care company policy.

Physician's Name: _____ **Fax:** _____

Physician's Signature: _____ **Date:** _____

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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Medication Profile

Patient Name: _____ **MRN:** _____

Other Pharmacy: _____ **Phone:** _____

Physician: _____ **Phone:** _____

Allergies: _____

☐ **All medication side effects, adverse reactions and contraindications reviewed with patient or caregiver.**

☐ **No OTC Medications**

☐ **No Home Remedies**

Route Key: IV, IM Subcut, PO, PR, SL, Topical, Enteral

Status Key: E = Existing N = New C = Change

Medications Infusion(s), Prescriptions and OTC	Drug Strength (concentration)	Dose Rate (quantity)	Frequency	Route	Start Date	Stop Date	Status
☐ Anaphylaxis Kit per OC protocol			p.r.n.				
☐ NS flush ☐ D5W flush	☐ 0.9% ☐ 5%	☐ 1 - 3 ml ☐ 3 - 5 ml ☐ 5 - 10 ml	Pre/post infusion and p.r.n.	☐ PIV ☐ MID			
				☐ CVC/ PICC			
				☐ PORT			
☐ NS flush	☐ 0.9%	☐ 1 - 5 ml ☐ 5 - 10 ml ☐ 10 - 20 ml	Pre/post lab draw	☐ PIV ☐ MID			
				☐ CVC/ PICC			
				☐ PORT			
☐ Heparin flush	☐ 10 units/ml ☐ 100 units/ml ☐ ____units/ml	☐ 0.5 - 3 ml ☐ 3 - 5 ml ☐ 5 ml	Post infusion and p.r.n.	☐ PIV ☐ MID			
				☐ CVC/ PICC			
				☐ PORT			

Date	Nurse Signature	Date	Nurse Signature

White - Medical Records Yellow - Patient