BrightStar Care
HOME CARE | MEDICAL STAFFING
A Higher Standard

INTRAVENOUS INFUSION VISIT NOTE

Client Name/ID: DOB:________ Date:________ TIME IN:______ TIME OUT:______

ASSESSMENT

Vital Signs
T________
P________
RR________
BP_____/_____
(R , L , Sit ,Stand , Lie)
Wt.________
☐ Client's Allergies Reviewed

Neuro ☐ WNL ☐ Oriented
☐ Tremors/Seizures
☐ Vertigo/Light Headed
Pupils reactive:
R________ L________
Speech: ☐ Clear ☐ Slurred

Respiratory ☐ WNL
☐ Clear
☐ Wheeze ☐ Rales /Rhonchi
☐ O2 @________ L/m (prn, cont.)
☐ Cough
☐ Productive
Color________

Cardiovascular ☐ WNL
☐ Angina ☐ Activity Intolerance
☐ Heart Sounds________
☐ Peripheral Pulses R____ L____
☐ Edema: LE R_____ L_____
UE R_____ L_____
☐ Other________

Gastro-Nutrition ☐ WNL
Appetite ☐ G ☐ F ☐ P
☐ Nausea/Vomit ☐ Difficult swallow
Intake: ☐ Adequate ☐ Inadequate
☐ Constipation ☐ Diarrhea
Last BM:________

SKIN ☐ WNL
☐ Warm ☐ Cool ☐ Dry Turgor: ☐ Intact ☐ Poor
☐ Pink ☐ Pale ☐ Bruise:________ ☐ Rash:________
Wound/Decub.: ☐ No ☐ Yes Location:________
Size:________ Stage:________
☐ Drainage ☐ NA ☐ Purulent ☐ Odor :________
Color:________ Amount:________

Musculoskeletal ☐ WNL
☐ Balance OK ☐ Weak
☐ Self-care deficit
☐ Abnormal Gait:________
☐ Limited ROM/Mobility

Urinary ☐ WNL
☐ Frequency ☐ Incontinence
☐ Retention____ ☐ S/S UTI________
☐ Foley/Suprapubic Catheter: ☐ Intact ☐ Leaking
☐ Clear ☐ Cloudy

Pain ☐ WNL
☐ N/A Intensity (0-10) Score:________
Location________
Type: ☐ Continuous ☐ Intermittent
Alleviated by:________

Mentation ☐ WNL
☐ Agitated ☐ Anxious ☐ Depressed
☐ Sleep Disturbances ☐ Suicidal
☐ Other________

CURRENT INTRAVENOUS STATUS ☐ No IV Access (Skip this section)

Current I.V. Site: ☐ WNL ☐ Needs to be restarted Type: ☐ Peripheral ☐ Midline ☐ PICC ☐ Port ☐ Other:________ ☐ Tender/Painful
☐ Drainage ☐ Edema ☐ Ecchymosis ☐ Erythema ☐ Sutures Current Dressing: ☐ Dry and Intact Type of dressing:________
I.V. Purpose: ☐ Hydration ☐ Meds ☐ Chemo ☐ Blood/Components ☐ Pain Mgt. ☐ TPN / Lipids ☐ Other________
Pump ☐ No ☐ Yes Type:________ Settings:________

INTRAVENOUS/ NURSING INTERVENTION

Access Start/Re-start/Lab Access : ☐ No ☐ Yes
Attempt:____ Site:________ Gauge:______ Length:______ Brand:______ Type:______ Lumens:______ Dressing________
Attempt:____ Site:________ Gauge:______ Length:______ Brand:______ Type:______ Lumens:______ Dressing________
I.V. Therapy or Meds Administered by: ☐ Nurse ☐ Client ☐ Family ☐ Other________
Specify I.V. Therapy/Med/Dose/Amt./Route/Timeframe:________

Flushing: ☐ NS ______mL ☐ before ☐ between ☐ after I.V. med and ☐ PRN ☐ Heparin: ☐ 10 units/mL or ☐ 100 units/mL ________mL after NS
Other:________
Changes Made this Visit: ☐ Dressing Changed ☐ Tubing changed ☐ Filter changed/added ☐ Injection cap changed
Labs Drawn: ☐ No ☐ Yes Lab drawn from (specify access)________ Specimen taken to________
IV Catheter Discontinued this visit: ☐ No ☐ Yes If yes, Reason: ☐ I.V. Therapy Complete ☐ Infiltration ☐ Site Rotated ☐ Cath. Occlusion ☐ Phlebitis
☐ Other________
Blood Return: Pre-Infusion ☐ Yes ☐ No Post-infusion ☐ Yes ☐ No
Nursing Actions: ☐ Direct care provided ☐ Assessed/Evaluated ☐ Observed:________
☐ Demonstrated/Instructed:________

POC REVIEW and CARE COORDINATION

POC Review: ☐ No Changes ☐ Changes needed-See POC ☐ Client/cg participates/agrees with POC ☐ Client/cg unable/unwilling to participate in POC
Coordinated With: ☐ Physician ☐ Pharmacy ☐ Client/Family Rep. ☐ RN/LPN providing services ☐ Infusion Co. ☐ Other:________
Discharge Plans: Next Visit Scheduled:________

Nursing Intervention Narrative:

Nurse's Signature & Title:________ Client/other Signature:________

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INTRAVENOUS INFUSION VISIT NOTE (p. 2)

Client Name/ID: **Date:**

VITAL SIGN RECORD

Medication Administered:______________________________
Lot #:________________ Expiration Date:________________
Infusion Start Time:________________ Infusion Stop Time:________________

Vital Signs goal every 15 minutes for the 1st hour; every 30 minutes for the next hour and then hourly until the end of infusion. For change in patient status and/ or rate change Vital Signs should be restarted at 15 minutes intervals and documented on a supplemental record.

	Time	B/P	T	P	R	Infusion Rate	Comments: Include any adverse reactions or additional Medication/ dose given
Baseline							
15 min							
30 min							
45 min							
60 min							
90 min							
2 hours							
3 hours							
4 hours							
5 hours							
6 hours							
7 hours							
8 hours							
Post Procedure							

RESPONSE TO THERAPY/ TEACHING-EDUCATION REVIEWED

☐ Pt tolerated therapy w/o adverse outcome ☐ Progressing toward goals New Problems identified: ☐ No ☐ Yes
If Yes:______________________________
☐ Adverse Drug Reaction ☐ Doses Missed ☐ Non-adherence ☐ Admitted to Hospital/ER ☐ New Medications Started ☐ Therapy D/C'd
☐ MD Notified ☐ Addressed/resolved ☐ Needs further action
☐ Med Administration/Site-Access Care ☐ Disease State/Reporting ☐ Infection Control/Hand hygiene ☐ Supplies/Ordering ☐ Signs & Symptoms report
☐ Client/Cg Verbalize Understanding: ☐ Independent ☐ Return Demonstration ☐ Additional Teaching Required (See notes)

Additional Notes:

____

Nurse's Name (Print)________________ Signature & Title:________________ Date:________